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U.S. Department of Justice
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*Issues and Practices*

# 1990 Update:

# AIDS in Correctional Facilities

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**Charles B. DeWitt**
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National Institute of Justice

U.S. Department of Justice
**Office of Justice Programs**
*National Institute of Justice*

# 1990 Update: AIDS in Correctional Facilities

by

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July 1991

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*Issues and Practices in Criminal Justice* is a publication series of the National Institute of Justice. Designed for the criminal justice professional, each *Issues and Practices* report presents the program options and management issues in a topic area, based on a review of research and evaluation findings, operational experience, and expert opinion on the subject. The intent is to provide criminal justice managers and administrators with the information to make informed choices in planning, implementing and improving progra ns and practice.

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# Foreword

HIV infection and AIDS continue to pose significant policy and management issues for correctional administrators. By October 1990, almost 7,000 AIDS cases had been reported among inmates in the United States' prisons and largest jail systems. While the early crisis atmosphere surrounding AIDS in prisons seems to have abated somewhat, the difficult long-term issues of education, housing, confidentiality, medical care, and psychosocial services remain.

Since 1985, the National Institute of Justice (NIJ) has conducted annual studies of the prevalence and institutional management of HIV/AIDS in Federal and State prison systems, as well as in the Nation's largest jails. Almost 53,000 copies of the first five editions of *AIDS in Correctional Facilities: Issues and Options* have been distributed to date.

This publication reports the results of the 1990 survey. It is one part of NIJ's ongoing effort to assist correctional administrators and other criminal justice professionals in addressing the issues raised by HIV/AIDS. HIV/AIDS places additional stress on already overburdened correctional systems. Much progress has been made in the development of a reasoned and humane correctional response. The National Institute of Justice hopes that this update will be of assistance to correctional systems' in the continued efforts to meet this challenge.

Charles B. DeWitt
*Director*
**National Institute of Justice**

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As always, this project could not have been completed without the cooperation of numerous correctional administrators, medical staff, legal counsel, and researchers. In particular, this year we would like to thank the following individuals who facilitated our site visits: Thomas A. Coughlin, III, Commissioner and Dr. Robert Greifinger, Deputy Commissioner/Chief Medical Officer, New York State Department of Correctional Services; and Frank Gunter, Executive Director, Dr. Dennis Kleinsasser, Director of Clinical Services, and R.T. Moore, Associate Director of Clinical Services, Colorado Department of Corrections; as well as other staff and inmates in both the New York and Colorado correctional departments.

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March 1991

# Table of Contents


*Page*

**Foreword** ..... iii

**Acknowledgements** ..... v

**Introduction** ..... ix

**Chapter 1.** Biomedical and Epidemiologic Research Developments ..... 1

**Chapter 2.** Epidemiology of HIV Disease in Correctional Facilities and the Population at Large ..... 9

**Chapter 3.** Tuberculosis and HIV Infection ..... 25

**Chapter 4.** HIV Education and Training ..... 29

**Chapter 5.** HIV Precautionary Measures ..... 39

**Chapter 6.** HIV Testing, Counseling, Confidentiality and Notification Policies ..... 43

**Chapter 7.** Housing and Correctional Management of Inmates with HIV Disease ..... 51

**Chapter 8.** Medical Care and Psychosocial Services ..... 57

**Chapter 9.** Legal Issues ..... 65

# List of Figures


*Page*

**Figure 1:** Cumulative Total of Adult/Adolescent AIDS Cases in the U.S. by Exposure Category, October 1990 ..... 11

**Figure 2:** Cumulative Total AIDS Cases Among Correctional Inmates and the Population at Large, U.S. 1985-1990 ..... 13

**Figure 3:** Distribution of Cumulative Total Inmate AIDS Cases, U.S., November 1985 and October 1990 ..... 14

**Figure 4:** Regional Distribution of Cumulative Total Inmate AIDS Cases, U.S. ..... 16

**Figure 5:** Distribution of Current Inmate AIDS Cases, U.S., October 1990 ..... 17

**Figure 6:** Available Seroprevalence Data from Mandatory Mass Screening of Inmates ..... 18

**Figure 7:** Seroprevalence Data from HIV Antibody Testing of Inmates in Blinded Epidemiologic Studies ..... 19

**Figure 8:** Available Data from HIV Antibody Testing of Other Inmate Categories ..... 21

**Figure 9:** Active Tuberculosis (TB) and Tuberculous Infection Among Inmates, October 1990 ..... 26

**Figure 10:** Tuberculosis (TB) Screening, Prophylaxis and Treatment of Inmates, October 1990 ..... 27

**Figure 11:** Live AIDS Education for Inmates, October 1989 and October 1990 ..... 31

**Figure 12:** Live AIDS Education for Correctional Staff, October 1989 and October 1990 ..... 32

**Figure 13:** AIDS Education in Correctional Facilities, October 1990 ..... 33

**Figure 14:** Correctional Systems Conducting Mandatory Mass Screening of Inmates, October 1990 ... 44

**Figure 15:** Summary of Correctional Policies on HIV Antibody Testing of Inmates, October 1990 .... 45

**Figure 16:** HIV Antibody Testing of Inmates, Mutually Exclusive Categorization, October 1989 and October 1990 ..... 47

**Figure 17:** Policies Regarding Disclosure/Notification of Inmates' HIV Antibody Test Results, October 1990 ..... 48

**Figure 18:** Housing Policies for Inmates with AIDS, ARC, and Asymptomatic HIV Infection, October 1990 ..... 52

**Figure 19:** Combinations of Housing Policies for Inmates with AIDS, ARC, and Asymptomatic HIV Infection, November 1984 and October 1990 ..... 53

**Figure 20:** Provision of Zidovudine for Inmates, October 1990 ..... 58

**Figure 21:** Provision of Aerosolized Pentamidine (AP) for Inmates, October 1990 ..... 59

# Introduction

This *1990 Update* presents results of the National Institute of Justice's sixth annual survey of HIV/AIDS in correctional facilities. The major policy trends identified in the past few years appear to be continuing. In particular, there has been no return to the sharp increases seen between 1986 and 1987 in the number of correctional systems adopting mass mandatory screening of inmates for HIV, and there has been a continuing movement away from blanket segregation of HIV-infected inmates and toward housing and programmatic mainstreaming of such prisoners. In general, these trends and others suggest that correctional policies for addressing HIV disease are coming increasingly to resemble policies pursued in the world outside corrections.

To conclude that correctional policies regarding HIV/AIDS are becoming more like policies in the outside world is not, however, to suggest that the correctional response to the epidemic is all that it should be. Indeed, just as this Update was being completed, the National Commission on AIDS released a report which is sharply critical of the correctional response in virtually all policy areas. The Commission states that "[t]he situation today for many prisoners living with HIV disease is nothing if not 'cruel and unusual.'...[T]oo many correctional facilities subject inmates to a series of unnecessary, arbitrary indignities which fundamentally affect their basic human rights." Medical care, psychosocial services, drug treatment opportunities, education and prevention programs, counseling and testing services, confidentiality and notification procedures, and services specifically targeting women and adolescents are all seriously deficient in correctional institutions, according to the Commission. The report offers a series of recommendations to address these deficiencies, headed by the proposal that the U.S. Public Health Service take the lead in developing and promulgating guidelines for prevention and treatment of HIV disease in prisons and jails.[1]

This year, for the first time, the NIJ survey was conducted over the telephone. We received responses from all 50 state correctional departments and the Federal Bureau of Prisons. In addition, we received a response this year from Puerto Rico. The Puerto Rican data are presented separately. Thirty-seven questionnaires were sent to large city and county jail systems in the United States and 27 (73 percent) responded. These systems continue to represent a good sampling of the largest American jail systems. (The District of Columbia system is included among city/county systems.) All twelve Canadian systems responded to the 1990 survey. Data presented in the report are current as of October–December 1989.

This year, we conducted site visits to New York State and Colorado to gather additional information regarding education, testing, housing, correctional management, and medical and psychosocial services. In New York, we interviewed the Deputy Commissioner/Chief Medical Officer, New York State Department of Correctional Services, and visited three facilities, where we interviewed staff and inmates. In Colorado, we interviewed the Executive Director of the Department of Corrections, as well as the Director and Associate Director of Clinical Services, staff and inmates at one facility.

The report includes the following sections: 1) biomedical and epidemiologic research developments; 2) epidemiology of HIV disease in correctional facilities and the population at large; 3) tuberculosis and HIV infection; 4) HIV education and training; 5) HIV precautionary measures; 6) HIV testing, counseling, confidentiality, and notification policy; 7) housing and correctional management of inmates with HIV disease; 8) medical care and psychosocial services; and 9) legal issues.

## Endnote

[1]National Commission on AIDS, *Report: HIV Disease in Correctional Facilities* March 1991.

# Chapter 1

# Biomedical and Epidemiologic Research Developments

This has been another year of progress in the fight against HIV disease and AIDS. Developments of significance have occurred in the understanding of the natural history of HIV, vaccines, antiretroviral therapies, therapies for opportunistic diseases, and the epidemiology of HIV transmission.

## Natural History of HIV Infection

A report published in September 1990 revealed that subtle neurologic abnormalities occur quite early in the course of HIV infection. The study of 29 HIV-seropositive homosexual men found that electrophysiologic abnormalities (the first neurologic effects of HIV infection) may begin in the asymptomatic state—that is, much earlier than previously thought.[1] Although these effects are observable on neurologic examination, they have not been associated with any detectable changes in behavior or neuropsychological measures of performance.

The continuing study of the San Francisco Men's Health Study cohort—which has been extremely important in charting the epidemiology and natural history of HIV—has yielded some new estimates of the incubation period between HIV infection and onset of diagnosed AIDS, and of survival time with AIDS. The study shows that the median incubation period for gay and bisexual men is 10 years (cumulative incidence of AIDS is 54 percent, 11 years after seroconversion). Investigation of this cohort has yielded ever-increasing estimates of the incubation period to AIDS since the first estimates, presented in 1985, of about 18 months. However, recent trends show a progression rate slower than predicted by previous models, suggesting a possible impact of antiviral therapies in infected persons.[2]

Median survival time for all AIDS patients in the San Francisco cohort is 12.1 months after diagnosis. Only 11 percent live for more than three years, but the survival time has improved for patients diagnosed in 1986 and 1987, with a median survival time of 14.4 months.[3]

## Development of Vaccines

More than two dozen candidate vaccines for HIV are currently under study. Several of these have been approved for clinical trials.[4] Initial results of the first Phase I (safety) studies of a candidate vaccine, rpg 160 (developed by MicroGeneSys, Inc. of West Haven, Connecticut), in healthy HIV-negative subjects reveal no clinical or laboratory toxicity and a high rate of HIV-antibody response after the administration of third and fourth doses. The studies also establish the feasibility of vaccine clinical trials which have been a matter of concern.[5] Although serious obstacles remain, scientists are now generally more optimistic about the possibility of developing an effective vaccine for HIV than they were only a few years ago. However, it is still likely to be at least five years before any vaccine could be widely available.

The accelerated process for approval of therapies has not been applied to vaccines. This is because it takes longer to test the safety and efficacy of vaccines and there is an even greater need for rigor in clinical trials and assurances of safety before a vaccine is made available. In particular, the health status of those in clinical trials must be scrupulously investigated. According to Wendy Mariner, a professor of public health at Boston University, "[i]f healthy persons took the vaccine outside of supervised trials, epidemiological evidence of the incidence of infection or adverse reactions...will be compromised. The results of trials could be meaningless."[6] Because an effective vac-

cine must block infection or the onset of disease, rather than improve the condition of someone already ill, it takes much longer to know the results of a clinical trial for a vaccine than for a therapy. In turn, because of the longer period of exposure to a candidate vaccine in a clinical trial, there is an even greater need to insure safety.

There is also a need to establish a substantial possibility of effectiveness before human trials are initiated. This requires prior testing of candidate vaccines in animals, which has been slow because of the lack of adequate animal models. However, some of the increased optimism regarding vaccines in the past two years has resulted from the first promising results in animals. These results are important not only because they suggest that certain candidate vaccines might be effective but also because they have revived hopes that appropriate animal models can be found.[7]

## Antiretroviral Therapies

Developments regarding therapies that attack HIV itself continue to focus on zidovudine (often called AZT), ddI, ddC, and soluble CD4. Trials are also beginning to yield data on combination chemotherapy regimens, using a succession of antiviral drugs, or antiviral drugs together with either immune modulators or drugs that reverse zidovudine's bone marrow toxicity. Preliminary laboratory data have been reported on several other potential therapies as well.

In connection with zidovudine, the only approved drug for AIDS, the most important development has probably been the demonstration of the drug's effectiveness in slowing disease progression in asymptomatic persons and those at the very early stages of HIV disease.[8] Some suggest that early use of zidovudine may account for reduced AIDS incidence rates in some populations.[9] As yet, however, it appears that zidovudine may achieve only a temporary slowing, rather than a longer-term blocking, of disease progression. It is not clear how long these salutary effects may last.

There are other unanswered questions as well. What is the optimum dose of zidovudine? What is the ideal schedule of administration?[10] As to dose, some recent findings suggest that a lower dosage of the drug (300-400 mg per day) is as effective as the standard dosage (1000-1500 mg) and is less toxic. These studies were conducted in patients with AIDS and lesser symptomatic HIV disease. One of these studies underlines the potential importance of low-dose zidovudine therapy both clinically and economically. That is, not only might it be possible to achieve equivalent clinical outcomes with fewer side effects, but these might also be achieved more cheaply than under current higher dosages.[11]

On the less optimistic side, it appears that zidovudine prophylaxis following accidental exposure to HIV is not effective in preventing infection.[12] Despite initial reports of lack of efficacy when the drug is administered following a possible exposure (e.g. via needlestick accident), clinical trials of prophylactic use of zidovudine are continuing, and the practice is increasing outside of the trials as well.[13]

Finally, more is being learned about the development of resistance to zidovudine in patients with HIV disease. Studies presented at the Sixth International Conference on AIDS in June 1990 indicate that resistance develops more quickly in patients with advanced disease. These findings, therefore, lend support to the argument for early zidovudine intervention.[14] On the other hand, laboratory evidence suggests that strains of zidovudine-resistant HIV are inhibited by other antiviral drugs now under clinical investigation. Consequently, these drugs have begun to be made available to patients who cannot tolerate or no longer derive benefit from zidovudine, through the so-called "parallel track"—an expanded access program outside of ongoing clinical trials.

There have been reports of increased death rates among AIDS patients receiving ddI under this expanded access program.[15] However, it appears that these individuals were in advanced stages of illness and that their deaths may not have been related to the use of the drug.[16] While there is clinical evidence that ddI may cause pancreatitis, peripheral neuropathy and other side effects, the drug is still considered promising.[17] Phase II-III (efficacy) clinical trials and expanded access to the drug are continuing. Studies are also attempting to establish the optimal dosage of ddI.

Another antiretroviral drug, ddC, is continuing to undergo trials in combination with zidovudine. There are preliminary indications that a combined regimen of the two compounds can achieve good clinical results with reduced side effects.[18]

Unlike the reverse transcriptase inhibitors (zidovudine, ddI, and ddC), recombinant soluble CD4 attempts to decoy viral particles away from the CD4 receptor to which they must bind in order to replicate. Soluble CD4 continues to be studied with "intense interest." Three completed Phase I (safety) studies have revealed no toxicity. However, early results have shown little activity against HIV replication. Modified forms of soluble CD4 are now under

study.[19] At the same time, laboratory data suggest that soluble CD4 may in fact escalate the infectivity of viral particles, whether or not it also has the capability of blocking infection.[20]

Research is also focusing on the regulatory functions of HIV and the cell-killing mechanism of the virus. For example, scientists are studying possible methods for inhibiting the tat and rev proteins which positively regulate the replication of HIV and for blocking the enzymes which have critical roles in the expression of the virus.[21]

Three other potential therapies should be mentioned. Promising early results on a new class of powerful reverse transcriptase inhibitors called TIBO (tetrahydro-imidazobenzodiazopene) derivatives were presented at the San Francisco AIDS conference. These drugs are being tested in a small clinical trial in Europe and have been shown to be nontoxic with some anti-HIV effect.[22]

In 1989, Compound Q (GLQ223), a protein extracted from the root of an Asian tuber, was shown to have *in vitro* effects against HIV replication in two types of immune cells. Phase I trials were approved by the Food and Drug Administration (FDA), but an unauthorized trial was also begun by Project Inform in San Francisco. After initially attempting to halt the unauthorized trial, the FDA allowed it to proceed. AIDS patients are continuing to take Compound Q, some with promising results. Scientists are at odds over the prospects for this drug, but studies continue.[23]

Finally, preliminary reports are appearing on studies of immunomodulatory drugs—that is, compounds that seek to restore the HIV-damaged immune system. These are not, strictly speaking, antiviral therapies, but the dis-tinction is not always clear. Indeed, a *New England Journal of Medicine* editorial commented that the possibility of a therapeutic approach combining antiretroviral and immunomodulatory drugs is "conceptually exciting." One early trial concludes that the immunomodulatory compound inosine pranobex (isoprinosine) delayed progression to AIDS in HIV-infected patients, but other trials have yielded less promising results, and there is clear need for confirmatory studies.[24]

## Therapies against Opportunistic Diseases

According to two leading investigators, "[u]ntil there is a cure for HIV infection,...the survival time and comfort of patients will depend greatly on therapies that [target] individual opportunistic infections."[25] Such therapies may prevent the onset of opportunistic infections, treat infections when they occur, and/or prevent their recurrence.

Perhaps, the opportunistic infection that has received perhaps the most successful attention is *Pneumocystis carinii* pneumonia (PCP). Primary and secondary PCP prophylaxis using aerosolized pentamidine, dapsone, or co-trimoxazole appear to be effective, especially if initiated when the patient's CD4 count is 200 or lower. Prophylaxis should be begun even earlier if AIDS or other symptomatic HIV disease is present.[26] However, aerosolized pentamidine is generally less effective with very ill patients. In addition, some patients have suffered recurrences of PCP and evidence of extra-pulmonary *P. carinii* infections following long-term aerosolized pentamidine therapy.[27]

Therefore, there is continuing interest in alternative therapies for PCP. Some are currently in trials. For example, a comparative trial of two combinations of standard antimicrobial drugs—trimethoprim-sulfamethoxazole (co-trimoxazole) and trimethoprim-dapsone—found that they were equally effective in treating mild-to-moderate first episodes of PCP in HIV-infected patients but that there were fewer adverse effects with the latter combination.[28] However, these drugs' effectiveness also declines in seriously ill patients. Trimethoprim is an inhibitor of DHFR, an enzyme critically involved in the spread of PCP. Other DHFR inhibitors under study include trimextrate (intravenous) and piritrexim (oral).

Finally, agents such as corticosteroids, which do not actually attack the PCP microbe, may be effective in reducing respiratory problems associated with moderate-to-serious cases of the disease when used as an adjunct to antimicrobial drugs. Survival times may also be improved by such adjunctive therapy.[29]

Progress on therapies for other opportunistic diseases has been slower. Thus far, the only effective therapy for toxoplasmosis is a combination of pyrimethamine and sulfadiazine, but this is unable to reverse most of the brain damage caused by the infection. Moreover, many patients cannot tolerate these drugs. Alternatives are under study, as well as the addition of gamma interferon to the standard combination.[30]

Bacterial infections such as tuberculosis and *Mycobacterium avium* are also common in HIV-infected patients. When given with other drugs, Isoniazid (INH) is generally effective in preventing and controlling active tuberculosis disease, but it is less effective against *M. avium*. Some other

standard anti-TB drugs such as aminoglycosides, rifamycin-group drugs, and ethambutol, have demonstrated some activity against *M. avium*, and several trials of combinations of these types of compounds have yielded promising initial results.[31]

Work on therapies for fungal and viral infections associated with HIV is also proceeding. For example, some orally administered alternatives to the intravenously administered and very toxic amphotericin B, until recently the only approved drug for cryptococcal meningitis, are showing promise. These are primarily compounds known as imidazoles.[32]

Currently available therapies for cytomegalovirus are also intravenously administered and very toxic. The leading drug now is ganciclovir. Acyclovir is less toxic than ganciclovir (DHPG) but also less effective. Foscarnet is not yet licensed but also must be given intravenously and has potentially serious side effects. However, some orally administered relatives of ganciclovir may be available soon. One such drug, HOE-602, is undergoing trials in Germany.[33]

Finally, two other herpes viruses, herpes simplex types 1 and 2, can be quite effectively treated with acyclovir. Unfortunately, however, there appear to be increasing numbers of strains of these viruses which are resistant to acyclovir. Vidarabine and Foscarnet may be alternative therapies for those resistant to acyclovir.[34]

## Drug Approval Policies and Access to Therapies

In recent years, primarily in response to the HIV epidemic, the federal government has dramatically changed the processes for approval of new drugs and has moved to expand access to therapies still in clinical trials.[35] Pressure brought by AIDS advocacy groups has played an important role in the accelerated process and expanded access, although these groups still have many complaints.

In May 1987, the FDA issued new regulations regarding investigational new drugs (IND). These regulations allow patients to be treated with drugs that have yet to complete clinical trials if no other alternative therapies are available.[36]

In late 1988, an accelerated review process for new drugs intended for treatment of persons with "life-threatening or extremely debilitating illnesses" was instituted. This means that the FDA can approve drugs for clinical use before they have completed the three phases of clinical trials. Notably, the FDA has suggested that it may apply traditional safety and efficacy standards more leniently to such drugs.[37]

Access to drugs independent of the formal approval process has been expanded in three basic ways. First, investigational drugs may be made available on a "compassionate use" basis. Second, under the "parallel track" system, announced by the FDA in 1989, experimental drugs are available to patients unwilling or unable to participate in trials of those drugs. The idea is controversial. Some argue that it vitiates the trials process, thereby potentially undermining the rigor of results. On the other side, some AIDS advocates argue that the parallel track represents "too little, too late" and that many patients are still deprived of promising treatments due to government "red tape." Finally, the FDA has liberalized regulations regarding importation of drugs not licensed for use in the United States. Persons with life-threatening illnesses are now permitted to import such drugs for their own use.[38]

## HIV Transmission Factors

The past year brought no information suggesting new means of HIV transmission, but it did bring the first report of patients possibly infected by a health-care provider, in this case a Florida dentist with AIDS. The Centers for Disease Control (CDC) has identified five of this dentist's patients who are infected with HIV. The dentist had performed multiple invasive procedures (e.g., extraction, periodontal scaling, root planing, restorative fillings, prophylaxis) on all of these patients subsequent to his diagnosis with AIDS. The CDC's epidemiologic investigation remains incomplete but suggests thus far that three of these patients (Patients A, B, and C) may have been infected during an invasive procedure performed by this dentist. All five patients deny sexual contact with the dentist. Two have no other identified HIV risk factors, and a third has unconfirmed risk factors. Records regarding the specific procedures performed on these patients were incomplete, and the dentist died before he could be interviewed. Standard infection control procedures were inconsistently practiced in the dentist's office, according to the CDC investigation. Because the HIV infections of these patients could not be linked with specific incidents, the CDC performed sequencing tests on the HIV proviral DNA present in the dentist, the patients and a group of controls to assess the relatedness of the viral strains. These tests reveal "a high degree of similarity" among the HIV strains of the dentist and Patients A, B, and C, but these are all distinct from that of a fourth Patient (D) and of the

controls. According to the CDC, the findings for the dentist and Patients A, B, and C are "consistent with previous instances in which cases have been linked epidemiologically." This rather guarded interpretation of the genetic test results led the CDC to conclude that "the case...is consistent with transmission of HIV to a patient during an invasive dental procedure, although the possibility of another source of infection cannot be entirely excluded."[39]

There continues to be controversy over the case. As is evident from the wording of its reports, the CDC is mindful of the weaknesses in the argument for attributing these patients' infections to dental procedures. First, the actual means of transmission during the dental procedures, if the infections in fact occurred then, remain unknown. Second, in all cases the patients' HIV status at the time of the procedures was unknown. Third, the two-year interval between Patient A's extraction and her AIDS diagnosis is extremely short.[40]

Nevertheless, the case has renewed concerns regarding HIV infection among health-care workers. The question has arisen: should HIV-infected health-care workers be barred from performing invasive procedures? If the answer is "yes," this inevitably leads, in "slippery slope" fashion, to the question of whether health-care workers should be screened for antibody to HIV. (These questions and arguments apply, by logical extension, to correctional and other emergency workers as well.) In February 1991, the CDC convened a meeting in Atlanta to consider the policy implications of the dental case. There was consensus regarding the need for improved barrier precautions during invasive procedures. Meeting participants did not recommend routing testing of health-care workers. However, it will be months before modified CDC guidelines on invasive procedures or on testing of health-care workers performing such procedures will be developed and promulgated.[41] In the meantime, the American Medical Association (AMA) has advised HIV-infected physicians "either [to] abstain from performing invasive procedures which pose an identifiable risk of transmission or disclose their sero-positive status prior to performing a procedure and proceed only if there is informed consent." In addition, the AMA has urged physicians who believe they have risk factors for HIV and who perform invasive procedures to determine their HIV status. The AMA's recommendations are based on the principle that "the health of patients must always be the paramount concern of physicians."[42]

This year, attention continued to be focused on the converse situation: health-care workers' risk of infection through contact with patients' blood. Some practitioners, such as orthopedic surgeon Lorraine Day, have argued strongly for preoperative HIV screening of patients. There have been 19 cases of HIV transmission from patient to health-care provider in the United States.[43]

A recent study at San Francisco General Hospital suggests that, at least in surgical procedures, knowledge of the patient's HIV status will not reduce the practitioner's likelihood of exposure to HIV during surgery. The authors conclude that their findings do not support the argument for preoperative HIV testing of patients. Indeed, they argue, the factors associated with increased likelihood of exposure are not amenable to intervention based on knowledge of patients' HIV status. These factors relate primarily to the type of procedure rather than to any characteristics of the patient. Finally, the authors estimate that one health-care worker in eight years would be infected with HIV during surgery at San Francisco General. This is a hospital at the high end of the risk scale due to the number of HIV-infected persons in its catchment area. Hospitals in low-risk areas might expect the equivalent of one infection per eighty years.[44] These findings are relevant to the question of whether it would be helpful to correctional officers and other emergency workers to know the HIV status of the persons with whom they routinely come into contact on the job. As with health-care workers, they seem to suggest that prevention based on "universal precautions" is far more prudent than an approach based on knowledge of the infection or risk status of individuals.

## Endnotes


1. I.J. Koralnik et al., "A Controlled Study of Early Neurologic Abnormalities in Men with Asymptomatic HIV Infection," *New England Journal of Medicine* September 27, 1990; 323:864-870.

2. G.W. Rutherford et al., "Course of HIV-1 in a Cohort of Homosexual and Bisexual Men: An 11 Year Followup Study," *British Medical Journal* 1990; 301:1183-1188.

3. G.F. Lemp et al., "Projections of AIDS Morbidity and Mortality in San Francisco," *Journal of the American Medical Association* March 16, 1990; 263:1497-1501.

4. J. Cohen, "AIDS Vaccine Conference: Is 'More' Better?" *Science* October 19, 1990; 250:369-370.

5. R. Dolin et al., "The Safety and Immunogenicity of an HIV-1 Recombinant gp 160 Candidate Vaccine in

Humans," *Annals of Internal Medicine* January 15, 1991; 114: 119–127; D.P. Bolognesi, "AIDS Vaccines: Progress and Unmet Challenges," *Annals of Internal Medicine* January 15, 1991; 114:161-162.

6. W.K. Mariner, "New FDA Drug Approval Policies and HIV Vaccine Development," *American Journal of Public Health* March 1990; 80: 336-341.

7. *Ibid.*

8. P.A. Volberding et al., "Zidovudine in Asymptomatic HIV Infection: A Controlled Trial in Persons with Fewer than 500 CD4-Positive Cells per Cubic Millimeter," *New England Journal of Medicine* April 5, 1990; 322: 941-949.

9. S. Broder et al., "Antiretroviral Therapy in AIDS," *Annals of Internal Medicine* October 15, 1990; 113: 604-618.

10. Broder, "Antiretroviral Therapy," p. 609.

11. M.A. Fischl et al., "A Randomized Controlled Trial of a Reduced Daily Dose of Zidovudine in Patients with AIDS;" A.C. Collier et al., "A Pilot Study of Low-Dose Zidovudine in HIV Infection," both in *New England Journal of Medicine* October 11, 1990; 323: 1009-1014, 1015-1021.

12. J.M.A. Lange et al., "Failure of Zidovudine Prophylaxis after Accidental Exposure to HIV-1," *New England Journal of Medicine* May 10, 1990; 322:1375-1377.

13. "AZT Use After On-the-Job Injury Increasing but Effect Uncertain," *AIDS Policy and Law* June 27, 1990, pp. 4,7.

14. M. Barinaga, "AIDS Meeting: Unexpected Progress," *Science* June 29, 1990; 248: 1596-1597.

15. G. Kolata, "Odd Surge Found in Deaths of Those Taking AIDS Drug," *New York Times*, March 12, 1990, pp. A1, B8.

16. J. Palca, "Trials and Tribulations of AIDS Drug Testing," *Science*, March 23, 1990; 247:1406.

17. J.S. Lambert et al., "2'-3'-Dideoxyinosine (ddI) in Patients with AIDS or ARC: A Phase I Trial;" T.P. Cooley et al., "Once-Daily Administration of 2'-3'-Dideoxyinosine (ddI) in Patients with AIDS or ARC: Results of a Phase I Trial," both in *New England Journal of Medicine* May 10, 1990; 322: 1340-1345.

18. Barinaga, "AIDS Meeting," p. 1797.

19. Broder, "Antiretroviral Therapy," pp. 611-612.

20. J.P. Moore et al., "Dissociation of gp120 from HIV-1 Virions Induced by Soluble CD4," *Science* 1990; 250: 1139-1142.

21. *Ibid.*, pp. 612-614.

22. Barinaga, "AIDS Meeting," p. 1597.

23. Palca, "Trials and Tribulations," p. 1406.

24. C. Pedersen et al., "The Efficacy of Inosine Pranobex in Preventing AIDS in Patients with HIV Infection;" S.L. Kweder, et al., "Inosine Pranobex – Is a Single Positive Trial Enough?" (Editorial) both in *New England Journal of Medicine* June 21, 1990; 322: 1757-1763, 1807-1809.

25. J. Mills and H. Masur, "AIDS-Related Infections," *Scientific American* August 1990; pp. 50-57.

26. G.S. Leoung et al., "Aerosolized Pentamidine for Prophylaxis Against *Pneumocystis carinii* Pneumonia: The San Francisco Community Prophylaxis Trial," *New England Journal of Medicine* September 20, 1990; 323:769-775; Mills and Masur, "AIDS-Related Infections," p. 52.

27. D. Duguay et al., "Radiographic Manifestations of *Pneumocystis carinii* Pneumonia (PCP) in Patients Receiving Aerosolized Pentamidine (AP) For Secondary Prophylaxis", Abstract No. TH.B.423; S. Scheibel et al., "Unusual Manifestations of *Pneumocystis carinii* Infection in HIV Positive Subjects in Prolonged Inhaled Pentamidine Prophylaxis," Abstract No. Th.B.425; R.D. McCabe et al., "Atypical PCP in Patients Receiving Inhaled Pentamidine Prophylaxis, "Abstract No. Th.B.426; D. Michel et. al., "Clinical Data of Disseminated Pneumocystis carinii Infection in 6 AIDS Patients Receiving Secondary Prophylaxis with Aerosolized Pentamidine," Abstract No. TH.B.427; G. Noskin et al., "Extrapulmonary *Pneumocystis carinii* in Patients Receiving Aerosolized Pentamidine," Abstract No. Th.B.428, all presented at the VI International Conference on AIDS, San Francisco, California, June 20-24, 1990.

28. I. Medina et al., "Oral Therapy for PCP in AIDS: A Controlled Trial of Trimethoprim-Sulphamethoxazole Versus Trimethoprim-Dapsone," *New England Journal of Medicine* September 20, 1990; 323: 776-782.

29. S. Gagnon et al., "Corticosteroids as Adjunctive Therapy for Severe PCP in AIDS: A Double-Blind, Placebo-Controlled Trial;" S.A. Bozzette et al., "A Controlled Trial of Early Adjunctive Therapy with Corticosteroids for PCP in AIDS," both in *New England Journal of Medicine* November 22, 1990; 323: 1444-1450, 1451-1457.

30. Mills and Masur, "AIDS-Related Infections," p. 53.

31. *Ibid.*, p. 54.

32. *Ibid.*, pp. 54-55.

33. *Ibid.*, pp. 56-57.

34. *Ibid.*, p. 57.

35. Mariner, "New FDA Drug Approval Policies," p. 336.

36. *Ibid.*, p. 336.

37. *Ibid.*, pp. 336-337.

38. *Ibid.*, pp. 337-338.

39. Centers for Disease Control, "Possible Transmission of HIV to a Patient During an Invasive Dental Procedure," *Morbidity and Mortality Weekly Report* July 27, 1990; 39: 489-492; CDC, "Update: Transmission of HIV Infection During an Invasive Dental Procedure - Florida," *MMWR* January 18, 1991; 40: 21-27, 33.

40. D.L. Breo, "'The Slippery Slope': Handling HIV-Infected Health Workers," *Journal of the American Medical Association* September 19, 1990; 264: 1464, 1466.

41. *Ibid.*

42. AMA Department of Public Information, "AMA Statement on HIV Infected Physicians," January 17, 1991.

43. Breo, "The Slippery Slope."

44. J.L. Gerberding et al., "Risk of Exposure of Surgical Personnel to Patients' Blood During Surgery at San Francisco General Hospital," *New England Journal of Medicine* June 21, 1990; 322: 1788-1793.

# Chapter 2

# Epidemiology of HIV Disease in Correctional Facilities and the Population at Large

## Patterns of HIV Disease in the Population at Large

This section describes the patterns of the HIV epidemic in the U.S. population. Topics include the recent heightened interest in HIV disease among women, the shifting proportions of AIDS cases attributed to diverse exposure categories, the continued overrepresentation of minority group members among persons with HIV disease, and estimates of the prevalence of HIV infection in the population.

### *Growth in AIDS Cases*

The number of AIDS cases continues to grow in the United States, even as public attention to the epidemic seems to dissipate. A total of over 43,000 new U.S. AIDS cases were reported to the Centers for Disease Control (CDC) during the year ending October 31, 1990. Although CDC calculations indicate that the rate of increase in overall AIDS incidence began to slow during the middle of 1987, the agency estimates that the number of new cases will continue to increase until about 1995.[1]

Cumulatively, over 152,000 adult/adolescent and almost 2,600 pediatric AIDS cases had been reported in the United States through October 1990. These figures include over 4,500 adult/adolescent and more than 160 pediatric cases reported from Puerto Rico, where the epidemic has reached extremely serious proportions.[2] Reflecting the slowing in the overall pace of epidemic growth; however, the increase in cumulative total cases between November 1, 1989 and October 31, 1990 was 38 percent compared to 50 percent in the same period the year before. In Canada, 4,139 adult and 54 pediatric cases had been reported through the end of September 1990.[3]

Although all states and metropolitan areas and many rural areas have been touched by the HIV epidemic, a small number of states still account for the majority of AIDS cases in the United States. Almost two-thirds of adult/adolescent cases have been reported from five states: New York (22 percent), California (19 percent), Florida (9 percent), Texas (7 percent), and New Jersey (6 percent). Almost 60 percent of pediatric case reports have come from three states and Puerto Rico: New York (29 percent), Florida (14 percent), New Jersey (10 percent), and Puerto Rico (6 percent). Thus, the epidemic among children is even more geographically concentrated. Pediatric AIDS is most common where HIV infection associated with injection drug use is most prevalent.

As of the end of 1990, over 100,000 deaths due to HIV disease had been reported in the United States. Almost one-third of these deaths were reported during 1990. In Canada, 2,755 AIDS deaths had occurred through the end of 1990. Sixty-three percent of all people reported as having HIV disease in the United States have died. The total U.S. case-fatality rate continues to rise (63 percent, as opposed to 60 percent in 1989).[4] AIDS emerged as a leading cause of death among American young adults in the 1980s. By 1989, it was the second leading cause of death among males 25-44 years of age, eclipsing heart disease, cancer, homicide, and suicide. Although most AIDS deaths have occurred among whites, death rates have been higher for blacks and Hispanics.[5] The effects of therapeutic drugs such as zidovudine (often called AZT) are yet to appear in these figures because many of the deaths are still occurring among people whose diagnoses occurred a number of years ago. In any case, the medications now available are likely to increase survival time marginally rather than to keep patients alive indefinitely.

## *Women, HIV Disease, and Correctional Facilities*

The CDC reports that the HIV epidemic is increasing disproportionately among women. Women accounted for 11 percent of all AIDS cases reported between November 1989 and October 1990. Between 1988 and 1989, AIDS diagnoses among women increased by 29 percent, as opposed to 18 percent among men. By 1987, AIDS was the eighth leading cause of death among women between 15 and 44 years of age. The CDC predicts that it will be among the top five causes of death for women in 1991. The HIV epidemic among women, as among men, disproportionately affects blacks and Hispanics. Blacks and Hispanics account for 19 percent of all women in the United States, but 72 percent of females diagnosed with AIDS.[6]

The epidemic among women has always been concentrated among the lower socioeconomic strata. As HIV infection increases among intravenous drug users, it will increasingly affect their sexual partners and children.

The number of women prisoners in the United States is rising even more rapidly than the number of incarcerated males. Females have often been even more underserved in prisons and jails than men, largely due to their historically small share of the total correctional population. However, female and male prisoners have different characteristics and different service needs. They are overwhelmingly sentenced for nonviolent crimes, they are probably more likely than men to be injection drug users (IDUs), their family responsibilities are generally greater, and a high percentage of female prisoners are either pregnant or postpartum. These factors suggest that special attention should be given to services for women in correctional facilities, including those educational, medical and psychosocial services related to HIV disease.[7]

## *AIDS Cases by Exposure Categories*

Figure 1 shows the breakdown of cumulative total AIDS cases reported to the CDC by exposure categories and gender. While the overall growth of the epidemic may be slowing, principally because of slower growth among gay/bisexual men in some parts of the country, it continues to increase among intravenous drug users and their sexual partners.

As of November 1, 1989, 61 percent of cumulative cases were attributed to male homosexual/bisexual contact, while 21 percent were attributed to injection drug use. A year later, the proportions have shifted another percentage point to 60 and 22 percent, respectively. There has been a 5 percent shift between the two categories since 1987. In New York State, as of October 1, 1990, 43 percent of cases were attributed to male homosexual/bisexual contact and 34 percent to IV drug use.[8]

These percentage shifts are revealed in differential case growth rates among exposure categories. Eighteen percent more AIDS cases among gay/bisexual men were reported between November 1989 and October 1990 than had been reported during the previous twelve months. By contrast, the increases between the two intervals were 25 percent for injection drug use associated cases and 44 percent for female cases attributed to sex with IDUs. Curiously, pediatric cases attributed to IV drug use in the mother or her sexual partners increased by only 15 percent.

Figure 1 also underscores the differences in the epidemic among males and females. Over half of all female cases have been among IDUs and another 32 percent have been attributed to heterosexual contact. Remarkably, a larger number of heterosexual contact cases have been reported among women than among men. Since the vast majority of heterosexual cases are acquired through sex with IDUs, it is clear that the epidemic among women is already overwhelmingly associated with drug use. This includes an increasing number of cases among female crack addicts whose habit drives them to increase their sexual activity, both as prostitutes and otherwise, thereby increasing their risk for acquiring HIV infection.[9]

## *HIV Disease by Racial/Ethnic Groups*

Blacks and Hispanics continue to be overrepresented among AIDS cases reported in the U.S. Through 1987, 60 percent of total AIDS cases were among whites, 25 percent among blacks, and 14 percent among Hispanics. By 1990, the percentages have shifted to 55, 28, and 16 percent, respectively. This 5 percent shift in cumulative cases from whites to minorities in three years reflects the more rapid growth of cases among blacks and Hispanics than among whites in the past several years.

## *Estimates of HIV Infection in the U.S. Population*

The HIV infection rate in the total U.S. population remains unknown. A household seroprevalence survey has been pilot-tested in two cities, but the CDC has decided not to implement it nationwide because the pilot tests appear to yield low estimates of seroprevalence compared

**Figure 1**

**CUMULATIVE TOTAL OF ADULT/ADOLESCENT AIDS CASES IN THE U.S. BY EXPOSURE CATEGORY, OCTOBER 1990[a]**

| Exposure Category | MALES | | FEMALES | | TOTAL | |
|---|---|---|---|---|---|---|
| | Number | % | Number | % | Number | % |
| Male Homosexual/Bisexual Contact | 90,599 | 66% | -- | -- | 90,599 | 60% |
| Intravenous (IV) Drug Use | 25,463 | 19 | 7,537 | 51% | 33,000 | 22 |
| Male Homosexual/Bisexual Contact and IV Drug Use | 10,215 | 7 | -- | -- | 10,215 | 7 |
| Hemophilia | 1,311 | 1 | 33 | 0 | 1,344 | 1 |
| Heterosexual Contact | 3,208 | 1 | 4,810 | 32 | 8,018 | 5 |
| Receipt of Transfusion | 2,192 | 2 | 1,380 | 9 | 3,572 | 2 |
| Other/Undetermined[b] | 4,427 | 3 | 1,056 | 7 | 5,483 | 4 |
| Total | 137,415 | 99%[c] | 14,816 | 99%[c] | 152,231 | 101%[c] |

[a]This table lists AIDS cases by *exposure* category, that is, by the behavior or circumstance to which HIV transmission is attributed.

[b]These individuals are thought to have had established risk factors, but information on these factors was not available for various reasons—e.g., they died before they could be interviewed, they refused to be interviewed, or they had forgotten or failed to admit high-risk behaviors.

[c]Figures do not add to 100 percent due to rounding.

*Source*: Centers for Disease Control (CDC). *HIV/AIDS Surveillance Report*, November 1989.

to rates derived from back-calculation based on numbers of AIDS cases and estimated incubation periods.[10] In the absence of a national survey, estimates must continue to rely on a composite of seroprevalence data, including those from blood donors, armed forces recruits, persons attending alternative testing sites and sexually transmitted diseases clinics, and various other "sentinel" populations. Based on these calculations, the Public Health Service continues to estimate that a minimum of 1 million persons in the United States are infected with HIV. At least 40,000 new infections occur each year among adults and adolescents, as well as 1,500-2,000 perinatal infections among infants.[11]

## Patterns of HIV Disease in Correctional Facilities

### *No Job-Related Cases of HIV Disease among U.S. or Canadian Correctional Officers*

As in all previous NIJ surveys, no confirmed cases of job-related HIV infection or AIDS were reported among U.S. or Canadian correctional officers. However, this year the first case anywhere of an occupational infection of a correctional officer was reported. This was an Australian case which did not result from the kind of exposure about

which correctional officers in the U.S. have generally expressed concern—that is, blood exposure during a fight or assault, a human bite, or a spitting incident. It was a much more extreme situation which, it would seem, is very unlikely to recur with any frequency. In the Australian case, an HIV-infected inmate with a history of mental instability and erratic behavior became angry, withdrew a syringe full of his own blood and injected it into an officer's buttocks. This was the equivalent of a small blood transfusion and, almost inevitably, the officer seroconverted to HIV.

The case evoked a great deal of concern among officers and prompted the New South Wales correctional system to institute mandatory HIV antibody testing of all inmates. In addition, the correctional department dramatically reduced the amount of personal property inmates were permitted to have in their cells with the objective of minimizing opportunities to conceal contraband such as needles. This step, in turn, caused the prisoners to riot and do substantial damage to the facility.[12]

While this incident did cause much concern among correctional officers and administrators, it is important to note that within six months of its occurrence, and only three months after the officer seroconverted to HIV, an Australian national conference on HIV in prisons produced a remarkable communique containing some extremely progressive recommendations. These recommendations include institution of pilot experiments on the distribution of condoms and needle exchange in prisons and the immediate widespread availability of bleach to prisoners. Strict confidentiality of all HIV-related information is also urged.[13] The conference which produced this document was attended by correctional officers and managers, correctional medical staff, AIDS educators, prisoners, government officials, academics, AIDS advocates, and others. The conference's achievement suggests that an incident of occupational infection need not preclude the achievement of consensus on rational prevention measures and other policy issues.

The CDC has begun a program to improve surveillance for occupational exposure and seroconversion to HIV among public safety and emergency workers, including correctional officers. Several states have received CDC grants for this purpose, as well as for developing educational materials to help emergency workers protect themselves against occupational HIV infection.[14]

### *AIDS Cases among Correctional Inmates*

Cumulative Total AIDS Cases. As of October-November 1990, a total of 6,985 AIDS cases had been reported among inmates in U.S. Federal, State, and larger city/county correctional systems. These represent cumulative totals since the beginning of the epidemic. Of these cases, 4,519 occurred among inmates of 45 state prison systems and the Federal Bureau of Prisons. Twenty-four hundred sixty-six (2,466) cases were reported by 25 city/county jail systems. Not reflected in these numbers are at least 393 cases in Puerto Rican correctional facilities.[15]

These figures require some qualification. The NIJ survey is not exhaustive of city/county jail systems, and the participating jail systems have varied slightly from year to year. Some components of the data necessary to calculate cumulative totals (i.e., current cases, cases among released individuals, and deaths while in custody) have not been available from every jurisdiction for each year of the survey. Therefore, we have had to estimate some figures based on prior years' reports. These estimates have always been very conservative. This, together with the inexhaustive scope of the survey and undercounting in some correctional systems that has come to light, suggest that our figures be considered minimum estimates of the extent of AIDS among U.S. inmates.

Bearing these qualifications in mind, Figure 2 shows that the rate of increase in cumulative total correctional cases (29 percent) is extremely low compared to all prior years and especially to last year's 72 percent increase. Moreover, the rate of increase in correctional cases has again fallen below that in the total U.S. population (38 percent) after one year of outstripping it. It may be that last year's sharp increase was largely an artifact of improved reporting in key jurisdictions such as New York State. In any case, unless the 1990 NIJ survey figures represent serious underestimates, the epidemic may be slowing among prisoners. This must be stated very tentatively, however, in view of the continued epidemic growth among IDUs, from whom prison populations are disproportionately drawn.

Canadian correctional systems report a cumulative total of 71 inmate AIDS cases, 14 in the Federal system and 57 in Provincial systems. This represents a 27 percent increase over 1989 figures.

State and Federal prison systems in the United States reported a cumulative total of 2,125 inmate deaths from AIDS. Responding city and county jail systems reported 379 inmate AIDS deaths. Forty-three percent of U.S. in-

**Figure 2**

**CUMULATIVE TOTAL AIDS CASES AMONG CORRECTIONAL INMATES AND THE POPULATION AT LARGE, U.S., 1985-1990**

| | Correctional Cases[a] | Cases in Population at Large[b] |
|---|---|---|
| November 1985 | 766 | 14,519 |
| October 1986 | 1,232 | 26,002 |
| % Increase 1985-86 | 61% | 79% |
| October 1987 | 1,964 | 41,770 |
| % Increase 1986-87 | 59% | 61% |
| October 1988[c] | 3,136 | 73,621 |
| % Increase 1987-88 | 60% | 76% |
| October 1989[d] | 5,411 | 110,333 |
| % Increase 1988-89 | 72% | 50% |
| October 1990[e] | 6,985 | 152,231 |
| % Increase 1989-90 | 29% | 38% |

[a]The figures in this and other tables represent inmate AIDS cases in the federal prison system, all 50 state prison systems, and a *sample* of 28-37 city and county jail systems (depending on the year of the NIJ Survey).

[b]Adult/adolescent cases only. Pediatric cases excluded.

[c]Figures for 1988 include 28 city/county jail systems.

[d]Figures for 1989 include 32 city/county jail systems.

[e]Figures for 1990 include 27 city/county jail systems.

*Sources*: CDC, *AIDS Weekly Surveillance Reports—U.S.*, November 4, 1985, October 6, 1986, October 5, 1987, October 3, 1988; CDC, *HIV/AIDS Surveillance Report*, November 1990; NIJ Questionnaire Responses.

mate AIDS deaths have occurred since the 1989 survey. Canadian systems reported a total of 11 inmate AIDS deaths, three of which occurred since the 1989 survey.

Although there may be indications that the HIV epidemic is slowing in prisons and jails, it is still a very serious problem. A recent analysis of inmate mortality in Maryland, for example, revealed that AIDS has been the leading cause of death among male inmates since 1987.[16] The relatively high HIV seroprevalence rates found in some correctional systems (detailed below) also suggest that this is not a problem which is about to disappear.

Figure 3 shows that the distribution of cumulative total AIDS cases across correctional systems is still quite uneven, although less so than in 1985. No State correctional systems reported their first inmate AIDS case since the 1989 survey; there remain five state systems that have never had any cases. Thirty-two percent of State/Federal prison systems have had 10 or fewer cases, while almost two-thirds of these systems have reported fewer than 25 inmate AIDS cases. At the other extreme, 16 State/Federal systems and seven responding city/county systems have had more than 50 cases. Eight State/Federal systems (16 percent) account for almost 80 percent of the cases in this jurisdictional category, while three responding city/county systems (11 percent) report more than three-quarters of the cases among this category.

**Figure 3**

**DISTRIBUTION OF CUMULATIVE TOTAL INMATE AIDS CASES, U.S., NOVEMBER 1985 AND OCTOBER 1990[a]**

| | State/Federal Prison Systems | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | November 1985 (N=51) | | | | October 1990 (N=51) | | | |
| Range of Total AIDS Cases | Number of Systems | % | Number of AIDS Cases | % | Number of Systems | % | Number of AIDS Cases | % |
| 0 | 26 | 51% | 0 | 0% | 5 | 10% | 0 | 0% |
| 1-3 | 15 | 29 | 24 | 5 | 5 | 10 | 10 | 0.2 |
| 4-10 | 5 | 10 | 30 | 7 | 6 | 12 | 39 | 1 |
| 11-25 | 2 | 4 | 42 | 9 | 16 | 31 | 241 | 5 |
| 26-50 | 1 | 2 | 33 | 7 | 3 | 6 | 96 | 2 |
| 51-100 | 1 | 2 | 95 | 21 | 8 | 16 | 547 | 12 |
| > 100 | 1 | 2 | 231 | 51 | 8 | 16 | 3,586 | 79 |
| Total | 51 | 100% | 455 | 100% | 51 | 101%[b] | 3,661 | 99%[b] |

| | City/County Jail Systems | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | November 1985 (N=33) | | | | October 1990 (N=27) | | | |
| Range of Total AIDS Cases | Number of Systems | % | Number of AIDS Cases | % | Number of Systems | % | Number of AIDS Cases | % |
| 0 | 13 | 39% | 0 | 0% | 2 | 7% | 0 | 0% |
| 1-3 | 10 | 30 | 16 | 5 | 4 | 15 | 9 | 0.4 |
| 4-10 | 7 | 21 | 43 | 14 | 3 | 11 | 17 | 1 |
| 11-25 | 1 | 3 | 12 | 4 | 4 | 15 | 63 | 3 |
| 26-50 | 1 | 3 | 40 | 13 | 7 | 26 | 195 | 8 |
| 51-100 | 0 | 0 | 0 | 0 | 4 | 15 | 299 | 12 |
| > 100 | 1 | 3 | 200 | 64 | 3 | 11 | 1,883 | 76 |
| Total | 33 | 99%[b] | 311 | 100% | 27 | 100% | 2,466 | 100% |

[a]The figures in this table represent the *minimum* number of correctional AIDS cases to date, since the NIJ survey does *not* include every U.S. county jail system.

[b]Due to rounding.

*Source*: NIJ Questionnaire Responses.

As shown in Figure 4, the regional distribution of cumulative total cases remains uneven as well, although, as with the distribution across State systems, less skewed than in 1985. Among State prison systems, more than half of the cases have occurred in the Middle Atlantic region (principally in New York and New Jersey), although this region's share has fallen steadily from the initial 75 percent in 1985. All other regions have increased their shares since 1985. A pattern dissimilar in some respects is revealed among the reporting city/county systems, where the share tradeoff has been predominantly between the Middle Atlantic and Pacific regions.

Current AIDS Cases. Figure 5 displays the distribution of current inmate AIDS cases across reporting correctional systems. Thirty-nine State and Federal prison systems reported 1,312 AIDS cases among current inmates. This is down slightly from the 1,351 reported in 1989. Eighteen responding city/county systems reported 560 current cases, up sharply from last year's 158. As noted last year, however, the turnover is so rapid in jails that figures on current AIDS cases are likely to fluctuate sharply even over short periods of time. Two Canadian systems reported five current cases, down from last year's seven cases.

Figure 5 also shows that 12 State systems (23 percent) and nine city/county systems (33 percent of those responding) reported no cases of AIDS among current inmates. At the other extreme, six State/Federal systems (12 percent) account for 78 percent of current AIDS cases in that jurisdictional category, while one city/county system (4 percent) contributes almost 70 percent of current cases in that category.

### *AIDS Incidence Rates*

The AIDS incidence rate in the United States was 17 cases per 100,000 population for the year ending October 31, 1990, up from 14 in the previous year. Incidence rates for states ranged from less than one per 100,000 to 46 (New York), with most under 10. Puerto Rico's rate was 56, higher than any of the states. Rates in metropolitan areas with populations in excess of 500,000 ranged from 4 (Grand Rapids, Michigan) to 126 (San Francisco).[17]

AIDS incidence rates are predictably higher among correctional inmates, given the concentration in these populations of individuals with histories of high-risk behavior, particularly IV drug use. Moreover, incidence rates in correctional populations vary widely, reflecting the uneven distribution of cases across systems.

Among State and Federal prison systems in the United States, AIDS incidence rates for 1990 ranged from 0 to 1047 cases per 100,000. Fourteen of these systems had AIDS incidence rates of less than 25 cases per 100,000, while 12 systems had rates over 100 cases.[18] The aggregate incidence rate for State/Federal systems in 1990 was 181 cases per 100,000, down from 202 in 1989.

Incidence rates in responding city/county jail systems ranged from 0 to 4,027, with 10 systems under 10 cases and 12 systems over 100 cases. The aggregate rate for responding jail systems was 560 cases per 100,000. Rapid jail population turnover renders these incidence rates for city/county systems extremely suspect. The aggregate AIDS incidence rate in Canadian systems was 15 cases per 100,000, sharply lower than the rates in U.S. systems.

### *Characteristics of Inmates with HIV Disease*

Data from the 1990 NIJ survey on cumulative total AIDS cases by exposure category and demographics are too fragmentary to report. However, scattered data from individual correctional systems suggest that inmate cases of HIV infection and AIDS are predominantly males, that blacks and Hispanics are overrepresented among them, and that IV drug use is the primary exposure category.

A recently completed study of HIV seroprevalence among incoming inmates in 10 unidentified U.S. prison and jail systems found that women intakes were significantly more likely than men to be HIV-seropositive. Seroprevalence rates were higher for women than for men in nine of the 10 systems. Across the 10 systems, HIV seroprevalence for women under 25 years old was 5.2 percent, as opposed to 2.3 percent among men under 25. Seroprevalence rates for women and men 25 or older were similar (5.3 percent and 5.6 percent, respectively). In addition, HIV seroprevalence was higher for non-whites across the 10 systems (4.8 percent) than for whites (2.5 percent).[19]

A study was conducted of incoming North Carolina inmates; 57 percent of all inmates were black, but 88 percent of HIV-seropositive inmates were black.[20] In the New York State prison system, 96 percent of AIDS cases have been among males, 48 percent among Hispanics, 38 percent among blacks, and 95 percent among IDUs.[21]

### *HIV Seroprevalence among Correctional Inmates*

Probably the most reliable HIV seroprevalence data on correctional inmates come from mandatory mass screen-

**Figure 4**

**REGIONAL DISTRIBUTION OF CUMULATIVE TOTAL INMATE AIDS CASES, U.S.**
**(Federal Prison System Excluded)[a]**

| | State Prison Systems | | | | City/County Jail Systems | | | |
|---|---|---|---|---|---|---|---|---|
| | November 1985 (N=50) | | October 1990 (N=50) | | November 1985 (N=28) | | October 1990 (N=32) | |
| Region | Total AIDS Cases | % | Total AIDS Cases | % | Total AIDS Cases | % | Total AIDS Cases | % |
| New England[b] | 16 | 4% | 284 | 7% | 0 | 0% | 8 | 0.3% |
| Middle Atlantic[c] | 327 | 75 | 2,315 | 55 | 222 | 71 | 1,329 | 54 |
| E.N. Central[d] | 6 | 1 | 258 | 6 | 8 | 3 | 31 | 1 |
| W.N. Central[e] | 0 | 0 | 35 | 1 | 1 | 0.3 | 15 | 1 |
| S. Atlantic[f] | 49 | 11 | 675 | 16 | 24 | 8 | 178 | 7 |
| E.S. Central[g] | 1 | 0.2 | 61 | 1 | 0 | 0 | 2 | 0.1 |
| W.S. Central[h] | 12 | 3 | 244 | 6 | 3 | 1 | 60 | 2 |
| Mountain[i] | 2 | 0.5 | 79 | 2 | 1 | 0.3 | 26 | 1 |
| Pacific[j] | 20 | 5 | 242 | 6 | 52 | 17 | 817 | 33 |
| Total | 433 | 100% | 4,193 | 100% | 311 | 101%[k] | 2,466 | 99%[k] |

[a]The regional divisions used in this table are standard geographic divisions and are not based on numbers of AIDS cases. The figures in this table represent the *minimum* number of correctional AIDS cases to date, since the NIJ survey does not include every U.S. jail system. Recent tightening of case identification and recording may partially explain the large increases in correctional AIDS cases in certain regions since last year.

[b]Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut

[c]New York, New Jersey, Pennsylvania

[d]Ohio, Indiana, Illinois, Michigan, Wisconsin

[e]Minnesota, Iowa, Missouri, North Dakota, South Dakota, Nebraska, Kansas

[f]Delaware, Maryland, District of Columbia, Virginia, West Virginia, North Carolina, South Carolina, Georgia, Florida

[g]Kentucky, Tennessee, Alabama, Mississippi

[h]Arkansas, Louisiana, Oklahoma, Texas

[i]Montana, Idaho, Wyoming, Colorado, New Mexico, Arizona, Utah, Nevada

[j]Washington, Oregon, California, Alaska, Hawaii

[k]Due to rounding

*Source*: NIJ Questionnaire Responses.

**Figure 5**

**DISTRIBUTION OF CURRENT INMATE AIDS CASES, U.S., OCTOBER 1990**

| Range of Current AIDS Cases | State/Federal Prison Systems October 1989 (N=51) Number of Systems | % | Number of AIDS Cases | % | City/County Jail Systems October 1990 (N=27) Number of Systems | % | Number of AIDS Cases | % |
|---|---|---|---|---|---|---|---|---|
| 0 | 12 | 23% | 0 | 0% | 9 | 33% | 0 | 0% |
| 1-3 | 13 | 25 | 30 | 2 | 7 | 26 | 15 | 3 |
| 4-10 | 11 | 22 | 69 | 5 | 6 | 22 | 40 | 7 |
| 11-25 | 7 | 14 | 124 | 9 | 2 | 7 | 26 | 5 |
| 26-50 | 2 | 4 | 66 | 5 | 2 | 7 | 95 | 17 |
| 51-100 | 3 | 6 | 200 | 15 | 0 | 0 | 0 | 0 |
| >100 | 3 | 6 | 823 | 63 | 1 | 4 | 384 | 69 |
| Total | 51 | 100% | 1,312 | 99%* | 27 | 99%* | 560 | 101%* |

*Due to rounding.

*Source:* NIJ Questionnaire Responses.

ing (mandatory, identity-linked testing of all incoming, current, or about-to-be released inmates) and from blinded studies. These two types of programs capture populations largely uninfluenced by selection biases.

The most up-to-date HIV seroprevalence data from mandatory screening programs are shown in Figure 6. Most of these rates are still one percent or lower. Rates are higher than one percent in Alabama, Georgia, Michigan, Nevada (females only), Utah (females only), Mississippi (females only) and New Hampshire (females only). The intake seroprevalence rate for the Federal Bureau of Prisons, based on an approximately 10 percent sample, fell below one percent for both men and women in 1990. It should be noted, however, that the states with the largest numbers of AIDS cases have not instituted mandatory screening in their prison systems. Some of these have undertaken blinded studies, which are discussed below.

Seroprevalence figures from blinded studies are displayed in Figure 7. Most of these are also quite low, but there are notable exceptions. The blinded study of prison and jail intakes in 10 jurisdictions cited above found generally higher HIV seroprevalence rates than those reported to the NIJ survey. In these 10 unidentified systems (some of which may also have reported data to the NIJ Survey), seroprevalence rates ranged from 2.1 percent to 7.6 percent for men and 2.5 percent to 14.7 percent for women. Moreover, the investigators were careful to include jurisdictions with both moderate and high AIDS incidence.[22]

**Figure 6**

**AVAILABLE SEROPREVALENCE DATA FROM MANDATORY MASS SCREENING OF INMATES**

| | Correctional System | Dates | Number Tested | Number Seropositive | % Seropositive |
|---|---|---|---|---|---|
| All Incoming Inmates | Alabama | 10/89-10/90 | 7,306 M+F | 88 M+F | 1.2% M+F |
| | Colorado | 10/89-10/90 | 3093 M<br>358 F | 20 M<br>1 F | 0.6 M<br>0.3 F |
| | Georgia | 7/89-5/90 | 20,435 M+F | 561 M+F | 2.7 M+F |
| | Idaho | 8/87-10/90<br>1987-10/89 | 3,000 M<br>50 F | 10 M<br>0 F | 0.3 M<br>0.0 F |
| | Iowa | 11/87-10/90 | 13,434 M+F | 26 M+F | 0.2 M+F |
| | Michigan | 4/90-2/91<br>4/90-2/91<br>4/90-2/91 | 22,669 M[a]<br>5,510 M[b]<br>1,895 F[b] | 378 M<br>18 M<br>42 F | 1.7 M<br>0.3 M<br>2.2 F |
| | Missouri | 1985-10/90 | 24,284 M+F | 127 M+F | 0.5 M+F |
| | Nebraska | 3/87-10/90 | 6,426 M+F | 21 M+F | 0.3 M+F |
| | New Hampshire | 1/87-9/89<br>10/89-10/90 | 1,760 M<br>92 F | 9 M<br>6 F | 0.5 M<br>6.5 F |
| | Oklahoma | 6/87-11/90 | 19,120 M<br>2,347 F | 51 M<br>3 F | 0.3 M<br>0.1 F |
| | Utah | 7/89-11/90 | 4,000 M<br>231 F | 33 M<br>6 F | 0.8 M<br>2.6 F |
| | Wyoming | 1/90-10/90 | 181 M<br>46 F | 1 M<br>0 F | 0.5 M<br>0.0 F |
| | Federal Bureau of Prisons[c] | 11/4/90-12/14/90 | 1,424 M<br>211 F | 7 M<br>1 F | 0.5 M<br>0.5 F |
| All Current Inmates | Mississippi | 7/89-10/89 | 7,743 M<br>310 F | 78 M<br>7 F | 1.0 M<br>2.3 F |
| | Oklahoma | 6/87 | 7,811 M<br>403 F | 34 M<br>0 F | 0.4 M<br>0.0 F |
| | Utah | 8/89-10/89 | 2,579 M<br>136 F | 19 M<br>5 F | 0.7 M<br>3.7 F |
| | Wyoming | 1984-10/90 | 74 M<br>0 F | 0 M<br>0 F | 0.0 M |
| All Inmates at Release | Alabama | 1987-1989 | 25,321 M+F | 2 M | 0.008M+F |
| | Missouri | 1985-10/90 | 16,435 M+F | 33 M+F | 0.2 M+F |
| | Wyoming | 7/90 | 34 M<br>0 F | 0 M<br>0 F | 0.0 M |
| | Federal Bureau of Prisons[c] | 1989 | 14,643 M+F | 224 M+F | 1.5 M+F |
| All Incoming & All Releasees | Nevada | 1/89-9/89 | 3,775 M<br>384 F | 34 M<br>8 F | 0.9 M<br>2.1 F |
| All Incoming & All Current | North Dakota | 1987-11/89 | 460 M<br>40 F | 3 M<br>0 F | 0.6 M<br>0.0 F |

[a]Males 24 or more years old.
[b]Males 18-24 years old.
[c]Federal Bureau of Prisons, unpublished data.
*Source* (unless otherwise noted): NIJ Questionnaire Responses.

**Figure 7**

**SEROPREVALENCE DATA FROM HIV ANTIBODY TESTING OF INMATES IN BLINDED EPIDEMIOLOGIC STUDIES[a]**

| Correctional System | Dates | Number Tested | Number Seropositive | % Seropositive |
|---|---|---|---|---|
| Arkansas | 7/90 | 698 M<br>23 F | 6 M<br>0 F | 0.9% M<br>0.0 F |
| California[b] | 4/88-5/88<br>(All incoming) | 5,372 M<br>807 F | 137 M<br>25 F | 2.5 M<br>3.1 F |
| Florida | 1988<br>(Consecutive intakes) | 1,000 M+F | 69 M+F | 6.9 M+F |
| Hawaii | 1/88-10/90 | 2,327 M<br>142 F | 22 M<br>0 F | 0.9 M<br>0.0 F |
| Illinois[c] | 4/89-6/89<br>(All incoming) | 501 M | 20 M | 4.0 M |
| New York (State) | 12/87-1/88[d]<br>(All incoming at Downstate Correctional Facility, Fishkill) | 494 M | 84 M | 17.0 M |
| | 10/87-1/88 | 500 F | 94 F | 18.8 F |
| North Carolina | 11/89-4/90 | 7942 M<br>784 F | 238 M<br>36 F | 3.0 M<br>4.6 F |
| Oregon | 9/90-10/90 | 437 M<br>76 F | 4 M<br>0 F | 0.9 M<br>0.0 F |
| South Carolina[e] | 4/88-6/88<br>(All incoming at 1 Reception Center) | 457 M<br>3 F | 8 M<br>0 F | 1.7 M<br>0.0 F |
| Tennessee | 7/88-8/90 | 4,461 M<br>448 F | 52 M<br>1 F | 1.2 M<br>0.2 F |
| Texas | 9/89-10/89 | 1,226 M+F | 30 M+F | 2.4 M+F |
| Virginia[f] | 6/89-8/89 | 1,287 M | 30 M | 2.3 M |
| Washington | 8/87-1/88 | 796 M | 5 M | 0.6 M |
| Wisconsin[g] | 1/88-8/88<br>(All incoming) | 1,621 M | 9 M | 0.6 M |
| Maricopa County, Arizona | 6/89-11/89 | 813 M | 28 M | 3.4 M |

Figure 7 (continued)

SEROPREVALENCE DATA FROM HIV ANTIBODY TESTING OF INMATES IN BLINDED EPIDEMIOLOGIC STUDIES[a]

| Correctional System | Dates | Number Tested | Number Seropositive | % Seropositive |
|---|---|---|---|---|
| Los Angeles County, California | 10/90 | 400 M<br>100 F | 11 M<br>1 F | 2.7 M<br>1.0 F |
| Santa Clara County, California | 10/86-10/89 | 348 F | 6 F | 1.7 F |
| Fulton County, Georgia | 7/88-12/88 | 160 M<br>40 F | 11 M<br>3 F | 6.9 M<br>7.5 F |
| New York City, New York | 9/89 | 1690 M<br>546 F | 272 M<br>140 F | 16.1 M<br>25.6 F |
| Quebec, Canada | 12/87-10/90 | 520 M<br>248 F | 44 M<br>19 F | 8.5 M<br>7.7 F |

[a]These studies are anonymous (not identity-linked) and conducted to determine seroprevalence rates in a population. Several systems did not specify the inmate category (for example, all incoming) tested in their study.

[b]J.A. Singleton et al., "HIV Seroprevalence Among Prisoners Entering the California Correctional System," California Department of Health Services, January 1989.

[c]Illinois Department of Corrections and Abt Associates Inc., unpublished data.

[d]B.I. Truman et al., "HIV Seroprevalence and Risk Factors Among Prison Inmates Entering New York State Prisons," Presented at 4th International AIDS Conference, Stockholm, June 1988.

[e]M.C. Monroe et al., "Studies of HIV Seroprevalence and AIDS Knowledge, Attitudes and Risk Behaviors in Inmates in the South Carolina Department of Corrections, 1988," December 1988.

[f]Commonwealth of Virginia, Department of Corrections, "HIV Seropositivity Study," October 1989.

[g]Wisconsin AIDS/HIV Program, Wisconsin Department of Health and Social Services, "HIV Seroprevalence and the Acceptance of Voluntary HIV Testing Among Newly Incarcerated Male Prison Inmates in Wisconsin," May 1989.

*Source* (unless otherwise noted): NIJ Questionnaire Responses.

The New York State and New York City correctional systems both appear to have HIV seroprevalence rates in excess of 15 percent. New York State correctional officials estimate that there are 8,000 HIV-infected prisoners in their system, of whom about 3,200 know their status.[23] In New York State, New York City, and a number of other jurisdictions, as noted above, the seroprevalence rates are higher for women than for men. This may reflect the fact that higher percentages of female than of male inmates tend to be IDUs. This is corroborated by findings from NIJ's Drug Use Forecasting system showing that, in many cities, higher percentages of female than male arrestees admit to having injected drugs.[24]

In addition to the data presented in Figures 6 and 7, there are higher estimates of HIV seroprevalence from several other jurisdictions. The New Jersey Department of Corrections estimates that 30-50 percent of its inmates are HIV-infected.[25] A blind study of Philadelphia jail intakes in 1989 found an HIV seroprevalence rate of 5 percent.[26] A study of jail intakes in Washington, D.C. suggests that 14 percent of male prisoners and 16 percent of female prisoners are HIV-seropositive.[27]

**Figure 8**

**AVAILABLE DATA FROM HIV ANTIBODY TESTING OF OTHER INMATE CATEGORIES[a]**

| | Correctional System | Dates | Number Tested | Number Seropositive | % Seropositive |
|---|---|---|---|---|---|
| Voluntary (Made Available to All): | Idaho | 1987-10/89 | 500 M<br>10 F | 0 M<br>0 F | 0.0 M<br>0.0 F |
| | Indiana | 1986-10/89 | 5,000 M<br>300 F | 30 M<br>1 F | 0.6 M<br>0.3 F |
| | Massachusetts (state prisons) | 10/87-10/89 | 2,401 M<br>429 F | 231 M<br>98 F | 9.6 M<br>22.8 F |
| | Massachusetts (county jails)[b] | 1/89-6/89 | 1,878 M+F | 278 M+F | 14.8 M+F |
| | Minnesota | 1/86-10/89 | 1,700 M<br>20 F | 24 M<br>1 F | 1.4 M<br>5.0 F |
| | New Mexico | 10/88-10/89 | 1,818 M<br>145 F | 9 M<br>0 F | 0.5 M<br>0.0 F |
| | Ohio[c] | 1/90-12/90 | 4,409 M<br>198 F | 68 M<br>2 F | 4.4 M<br>1.0 F |
| | Oregon | 11/88-10/89 | 354 M<br>76 F | 3 M<br>2 F | 0.8 M<br>2.6 F |
| | Rhode Island[d] | 10/89-3/90 | 4,110 M<br>264 F | 160 M<br>32 F | 3.9 M<br>12.1 F |
| | Washington | 10/85-10/89 | 1,445 M<br>46 F | 34 M<br>2 F | 2.4 M<br>4.3 F |
| | West Virginia | 10/89-10/90 | 257 M<br>0 F | 0 M<br>0 F | 0.0 M<br>0.0 F |
| | Maricopa County, (Pheonix) Arizona | 6/89-11/89 | 357 M<br>121 F | 19 M<br>7 F | 5.3 M<br>5.8 F |
| | Orange County, California | 1983-10/89 | 1,024 M<br>1,784 F | 40 M<br>55 F | 3.9 M<br>3.1 F |
| | Santa Clara County, California | 10/85-10/89 | 47 M<br>24 F | 8 M<br>3 F | 17.0 M<br>12.5 F |
| | Ventura County, California | 1/88-10/89 | 300 M<br>50 F | 3 M<br>0 F | 1.0 M<br>0.0 F |
| | Broward County, Florida | 1/89-10/89 | 137 M<br>120 F | 42 M<br>25 F | 31.0 M<br>21.0 F |
| | Suffolk County, (Boston) Massachusetts | 11/88-11/89 | 364 M | 59 M | 16.2 M |
| | Harris County, (Houston) Texas | 7/87-10/89 | 1,048 M<br>1,070 F | 163 M<br>48 F | 15.6 M<br>4.5 F |

Figure 8 (continued)

AVAILABLE DATA FROM HIV ANTIBODY TESTING OF OTHER INMATE CATEGORIES[a]

| | Correctional System | Dates | Number Tested | Number Seropositive | % Seropositive |
|---|---|---|---|---|---|
| Clinical Indications | Fulton County, (Atlanta) Georgia | 7/88-12/88 | 142 M<br>26 F | 46 M<br>10 F | 32.4 M<br>38.5 F |
| | South Carolina[e,f] | 1988 | 1,034 M<br>185 F | 25 M<br>2 F | 2.4 M<br>1.1 F |
| All High-Risk Behaviors | Oklahoma | 6/87 | 7,811 M<br>403 F | 34 M<br>0 F | 0.4 M<br>0.0 F |
| IDUs | Montana | 1/89-11/89 | 67 M | 2 M | 3.0 M |
| | King County, (Seattle) Wasington | 11/87-9/89 | 786 M<br>324 F | 22 M<br>4 F | 2.8 M<br>1.2 F |
| | Orange County, California | 1/88-12/88 | 766 F | 12 F | 1.5 F |
| | Sacramento County, California[g] | 1987-1988 | 422 M+F | 15 M+F | 3.5 M+F |

[a]This table does *not* present overall seroprevalence rates. Except for the "Incident Involvement" category, the figures in this table represent self- or clinically-selected inmates, and therefore represent selection bias. For example, inmates who have engaged in high-risk behaviors may be more likely to want to be tested and are more likely to be HIV-seropositive than those who have not. Therefore, the figures in this table are likely higher than seroprevalence rates in these total correctional populations.

For all seropositivity figures presented in this report (except for blinded epidemiologic studies, which are normally short-term and controlled), there exists the possibility of double counting of *recividist* offenders.

[b]Massachusetts Sheriffs Association Task Force on AIDS, "AIDS: The Current Situation in County Corrections: An Update," October 1989.

[c]Ohio Department of Rehabilitation and Correction, unpublished data.

[d]P.S. Dixon et al., "Rhode Island's Cooperative HIV Management Program for Prison Inmates," (draft submitted for publication), Table 2, p. 16.

[e]M.C. Monroe et al., "Studies of HIV Seroprevalence and AIDS Knowledge, Attitudes and Risk Behaviors in Inmates in the South Carolina Department of Corrections, 1988," December 1988.

[f]All Inmates Presenting at Sick Call.

[g]"Coordinated Community Programs for HIV Prevention Among IVDUs — California, Massachusetts," *MMWR*, June 2, 1989; 38: 370.

*Source* (unless otherwise noted): NIJ Questionnaire Responses.

Figure 7 includes the first HIV seroprevalence study from a Canadian correctional system. These results from Quebec's Provincial system are surprisingly high—over 8 percent among men and almost 8 percent among women.

Figure 8 brings together results from a range of other types of tests: voluntary/on-request tests, tests in the presence of clinical indications, and tests of persons with histories of high-risk behavior. All of these data cover subsets of prisoners affected by some form of selection bias. These biases are difficult to interpret but make the results inapplicable to the total correctional population in that system.

Results of voluntary/on-request testing are difficult to interpret because it is unclear whether individuals who perceive themselves to be at high risk or low risk, or some combination of the two, are likely to come forward for testing. If the mix reflects the mix of high- and low-risk individuals in the total population of the system, the results might be representative, but again, there is no way to know this. In any case, the results of voluntary testing are quite disparate, with some systems showing rather high seroprevalence rates among volunteers. Testing in the presence of clinical indications for HIV disease ought to overstate the HIV infection rate in the entire correctional population, as should testing of persons with histories of high-risk behaviors. Seroprevalence rates among incarcerated IDUs may indicate the infection rates among IDUs on the street in those jurisdictions. If so, the results from California, Montana, and Washington shown in Figure 8 suggest that HIV infection rates among IDUs in those places are still quite low.

### *HIV Transmission among Correctional Inmates*

HIV transmission among inmates remains a matter of serious concern. As reported in previous updates, the available data on this subject are fragmentary. They suggest that transmission occurs at quite low rates in correctional facilities. Nevertheless, applying the HIV transmission rate found in a Maryland study (0.5 percent per year)[28] to the total prison population of that state yields the not insignificant estimate of 60 transmissions per year. It should be noted that the Maryland study was methodologically flawed in that participation was voluntary which introduced uninterpretable selection bias.

## Endnotes


1. Centers for Disease Control, *HIV/AIDS Surveillance Report*, November 1990; Table 1; CDC, "Update: AIDS—United States, 1989;" *Morbidity and Mortality Weekly Report* 1990; 39: 81-86; CDC, "HIV Prevalence Estimates and AIDS Case Projections for the United States: Report Based Upon a Workshop," *MMWR*, November 30, 1990; 39: No. RR-16.

2. Centers for Disease Control, *HIV/AIDS Surveillance Report*, November 1990; Table 1.

3. Penny Nault, Federal Centre for AIDS (Canada), personal communication, January 4, 1991.

4. CDC, *HIV/AIDS Surveillance Report*, January 1990 and January 1991; Federal Centre for AIDS (Canada), *Surveillance Update: AIDS in Canada* January 7, 1991; CDC, "Mortality Attributable to HIV Infection/AIDS—United States, 1981-1990," *MMWR*, January 25, 1991; 40: 41-44.

5. *Ibid.*

6. CDC, "AIDS in Women—United States," *MMWR* November 30, 1990; 39: 845-846; S.Y. Chu et al., "Impact of the HIV Epidemic on Mortality in Women of Reproductive Age, United States," *Journal of the American Medical Association* 1990; 264: 225-229.

7. Brenda V. Smith, "Women in Prison and HIV Infection: Perspectives and Recommendations," Testimony before the National Commission on AIDS, New York, August 17, 1990; National Institute of Justice, "1988 Drug Use Forecasting Annual Report," *NIJ Research in Action*, March 1990, p.9.

8. Bureau of Communicable Disease Control, New York State Department of Health, *AIDS Surveillance Monthly Update for Cases Reported Through September 1990* Table 2 C, p. 18.

9. Gloria Weissman et al., "The Relationship Between Crack Cocaine Use and Other Risk Factors Among Women in a National AIDS Prevention Program—U.S., Puerto Rico, and Mexico," Abstract No. S.D. 124, Sixth International Conference on AIDS, San Francisco, California, June 23, 1990.

10. CDC, "Pilot Study of a Household Survey to Determine HIV Seroprevalence," *MMWR*, January 11, 1991; 40: 1-5.

11. CDC, "HIV Prevalence Estimates and AIDS Case Projections for the United States," *MMWR*, November 30, 1990; 39: No. RR-16.

12. S.J. Eggar and H. Heilpern, "HIV Infection in Australian Prisons," paper presented at a national conference on "AIDS/HIV and Prisons," Melbourne, November 19, 1990.

13. Communique, AIDS/HIV and Prisons Conference, Melbourne, Australia, November 21, 1990.

14. "Grants Available for Surveillance of Emergency Workers, CDC Says," *AIDS Policy and Law* July 25; 1990, p. 9.

15. NIJ Survey response, 1990. The Puerto Rican officials reported 244 AIDS cases among current inmates and 149 deaths from AIDS among inmates. They were not able to provide figures on cases among released inmates.

16. M.E. Salive et al., "Death in Prison: Changing Mortality Patterns Among Male Prisoners in Maryland, 1979-1987," *American Journal of Public Health* December 1990; 80:1479-1480.

17. The incidence rate per 100,000 population is a standard measure used to facilitate comparisons. The incidence rates for the total population were calculated by CDC as follows: Incidence rate = Total number of AIDS cases reported during the year ended October 31, 1990 x 100,000/Total U.S. population. CDC, *HIV/AIDS Surveillance Report* November 1990; Figure 1, p. 3 and Table 2, p. 7.

18. Incidence rates for correctional inmates were calculated as follows: Incidence rate = Current AIDS cases in system x 100,000 / Current inmate population of system. The reported number of current AIDS cases may underestimate the total number of cases reported in the year since the 1989 survey, but most correctional systems do not keep statistics on AIDS cases by year reported. Using the current case figure may thus slightly underestimate the real annual incidence rate in a correctional system.

19. D. Vlahov et al., "Prevalence of Antibody to HIV-1 Among Entrants to U.S. Correctional Facilities," *Journal of the American Medical Association* March 6, 1991; 265:1129-1132.

20. Parker Eales, "The Seroprevalence of HIV Infection in All Incoming Inmates Admitted to the North Carolina Department of Correction, November 1989-April 1990," Legislatively mandated study, May 1990.

21. Bureau of Communicable Disease Control, New York State Department of Health, *AIDS Surveillance Monthly Update for Cases Reported through September 1990*, Table 2 D, p. 19.

22. D.Vlahov et al., "Prevalence of Antibody to HIV-1 Among Entrants to U.S. Correctional Facilities," p. 1129-1132.

23. Interview with Dr. Robert Greifinger, Deputy Commissioner/Chief Medical Officer, New York State Department of Correctional Services, Fishkill Correctional Facility, New York, October 24, 1990.

24. National Institute of Justice, "1988 Drug Use Forecasting Annual Report," p 9.

25. This estimate is cited in Catherine A. Hannssens, New Jersey Department of the Public Advocate, Office of Inmate Advocacy, "AIDS Issues for New Jersey's Incarcerated," Testimony before the National Commission on AIDS, New York, August 17, 1990, p. 1.

26. B. Davidson et al., "Retrovirus Seroprevalence in the Short-Term Incarcerated: The Philadelphia Prison Seroprevalence Study," Abstract No. M.A.O.39, Fifth International Conference on AIDS, Montreal, June 5, 1989.

27. Brenda V. Smith, "Women in Prison and HIV Infection," p. 6.

28. T.F. Brewer et al., "Transmission of HIV-1 Within a State-Wide Prison System," *AIDS 88* October 1988; 2:363-367.

# Chapter 3

# Tuberculosis and HIV Infection

## The TB-HIV Link

After declining dramatically in the United States between the early 1950s and the mid 1980s, there has been a serious resurgence of tuberculosis (TB) in the past five years. This resurgence has been closely related to the epidemic of HIV. Persons with HIV infection are more susceptible to progress from tuberculous infection to active TB disease. These linked epidemics have struck hard in poor and minority communities, and especially among IDUs—in other words, populations overrepresented among prison inmates.

Thus, it is no surprise that HIV-associated TB is on the rise in correctional facilities. Moreover, the close and crowded environments of prisons and jails offer perfect opportunities for the spread of TB by those with active disease. The CDC and other public health agencies are greatly concerned about the growing problem of tuberculosis in prisons and jails and urge correctional officials to take steps to prevent and control TB in their institutions.

## Prevalence of Tuberculosis in Correctional Populations

Figure 9 shows that 27 State and Federal prison systems report a total of 317 cases of active tuberculosis disease among their inmates. According to Chief Medical Officer Robert Greifinger, there were 80 cases of active TB among New York State prison inmates as of the end of 1990.[1] Ten systems were unable to provide numbers of cases. This count should, therefore, be considered an absolute minimum estimate. In the city/county jail systems that responded to the NIJ survey, a total of 301 cases were reported, and Canadian systems reported only two cases.

Figure 9 also displays the percentage of their inmates confirmed TB-positive (that is, TB-infected but not with active TB disease). In 1989, surprisingly large numbers of correctional systems did not know this information. The percentage of systems that do not know are down substantially since 1989 among State/Federal systems (although still almost 20 percent) and down slightly among city/county systems. More than half of Canadian systems still report having no information on the number of TB-positive inmates in their facilities.

As shown in Figure 10, virtually all responding U.S. correctional systems reported conducting TB screening of inmates. Fewer Canadian systems conduct TB screening. The substantial number of systems without information on the prevalence of TB infection underscores the need for better screening and data maintenance programs.

Among systems providing responses, 17 State/Federal systems in the U.S. reported that more than 10 percent of their inmates were TB-positive. Four responding city/county jail systems and one Canadian system reported rates of higher than 10 percent. Tuberculosis specialists at CDC believe that infection rates of 10-20 percent are not uncommon in correctional facilities.[2]

## Tuberculosis Screening and Treatment

The Centers for Disease Control has issued guidelines for the prevention and control of tuberculosis in correctional facilities. The guidelines recommend early case finding, universal reporting of cases to public health authorities, periodic inmate screening (using the intracutaneous Mantoux tuberculin test rather than the multiple puncture or tine method), and careful monitoring of inmates and staff (including chest x-rays for tuberculin-positive individuals and those at risk for HIV, and HIV antibody tests for all tuberculin-positive inmates and those with active TB), identification and followup of those who may have been exposed to persons with active TB, medical isolation of inmates with active TB disease, and careful adherence to standard protocols for prophylaxis and treatment.[3]

**Figure 9**

**ACTIVE TUBERCULOSIS (TB) AND TUBERCULOUS INFECTION AMONG INMATES, OCTOBER 1990**

| | Number of Active TB Cases Under Treatment | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | U.S. State/Federal Prison Systems (N=51) | | | | U.S. City/County Jail Systems (N=27) | | | |
| Range of Cases | Number of Systems | % | Number of Cases | % | Number of Systems | % | Number of Cases | % |
| Unknown | 10 | 20% | -- | --% | 2 | 7% | -- | --% |
| 0 | 14 | 27 | 0 | 0 | 7 | 26 | 0 | 0 |
| 1-3 | 11 | 22 | 20 | 6 | 7 | 26 | 13 | 4 |
| 4-10 | 8 | 16 | 44 | 14 | 6 | 22 | 37 | 12 |
| 11-24 | 4 | 8 | 55 | 17 | 1 | 4 | 24 | 8 |
| 25-50 | 2 | 4 | 65 | 20 | 2 | 7 | 65 | 22 |
| 51-100 | 2 | 4 | 133 | 42 | 1 | 4 | 52 | 17 |
| >100 | 0 | 0 | 0 | 0 | 1 | 4 | 110 | 37 |
| Total | 51 | 101%[a] | 317 | 99%[a] | 27 | 100% | 301 | 100% |

| | Percentage of Inmates Confirmed PPD-Positive | | | | | |
|---|---|---|---|---|---|---|
| | U.S. State/Federal Prison Systems (N=51) | | U.S. City/County Jail Systems (N=27) | | Canadian Systems (N=12) | |
| Range of Percentages | Number of Systems | % | Number of Systems | % | Number of Systems | % |
| Unknown | 9 | 18% | 8 | 30% | 8 | 67% |
| 0 | 5 | 10 | 3 | 11 | 1 | 8 |
| 1-10 | 20 | 39 | 12 | 44 | 2 | 17 |
| 11-25 | 16 | 31 | 3 | 11 | 1 | 8 |
| 26-50 | 1 | 2 | 1 | 4 | 0 | 0 |
| 51-100 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total | 51 | 100% | 27 | 100% | 12 | 100% |

[a]Due to rounding.

*Source*: NIJ Questionnaire Responses.

**Figure 10**

**TUBERCULOSIS (TB) SCREENING, PROPHYLAXIS AND TREATMENT OF INMATES, OCTOBER 1990**

| Procedure | U.S. State/Federal Prison Systems (N=51) | | U.S. City/County Jail Systems (N=27) | | Canadian Systems (N=12) | |
|---|---|---|---|---|---|---|
| | Number of Systems | % | Number of Systems | % | Number of Systems | % |
| Screening Conducted: | 50 | 98% | 23 | 85% | 4 | 33% |
| TB Prophylactic Medication Provided to the Following Categories of TB Skin Test Positive Inmates: | | | | | | |
| All Regardless of Age | 17 | 33 | 14 | 52 | 1 | 8 |
| All Under Age 35 | 41 | 80 | 14 | 52 | 1 | 8 |
| All HIV-Infected | 36 | 71 | 15 | 56 | 1 | 8 |
| Those Recently in Contact with a TB Case | 39 | 76 | 16 | 59 | 5 | 42 |
| Recent Skin Test Converters | 45 | 88 | 17 | 63 | 4 | 33 |

*Source*: NIJ Questionnaire Responses.

As noted above, virtually all responding U.S. correctional systems reported screening inmates for tuberculous infection. The CDC recommends screening of all new inmates and staff with annual retesting. Jail systems may not be able to implement these recommendations due to rapid inmate turnover, but the CDC suggests that such facilities at least medically evaluate any prisoner with TB symptoms (using sputum smears and cultures and/or chest x-rays). Also recommended is immediate tuberculin testing of any persons having close contact with active TB cases.[4]

The CDC recommends prophylaxis with Isoniazid (INH) or its equivalent for all tuberculin-positive prisoners. The highest priority cases for prophylaxis are recent tuberculin skin test converters and those with both positive tuberculin tests and confirmed or suspected HIV infection. The recommended prophylactic dosage of INH is 300 mg daily or 900 mg twice each week. Careful monitoring is necessary to insure that the medication schedule is followed and to identify any symptoms or adverse reactions.[5]

NIJ surveys indicate that there was more widespread adherence to the CDC recommendations for INH prophylaxis in correctional institutions in 1990 than in 1989. Figure 10 shows that almost 90 percent of State/Federal systems institute prophylaxis for recent skin test converters, and about three-quarters do so for HIV-infected inmates and those in contact with an active TB case. However, only one-third of State/Federal systems are following CDC's recommendation that prophylaxis be given to *all* tuberculin-positive inmates. Notably, over half of responding city/county systems have such a policy.

There is some controversy regarding INH therapy. Physicians are seeing increasing numbers of TB cases which are resistant to INH. In such cases, the alternatives are experi-

mental drugs (e.g., amikacin, which is expensive, hard to obtain, and must be administered by injection every 12 hours) and possibly toxic drugs (e.g., streptomycin).[6] In addition, in view of concerns regarding the effectiveness, lengthy regimen required, and possible toxicity of INH, the American College of Chest Surgeons and the CDC have issued new guidelines which call only for the *evaluation* of all PPD-positive patients for possible INH therapy.[7] According to the new CDC guidelines, persons with any of the following risk factors should be considered "candidates" for preventive therapy: (1) HIV infection or risk factors for HIV infection, (2) close contact with persons with newly diagnosed infectious TB, (3) recent PPD conversion, (4) abnormal chest x-rays, (5) history of injection drug use, (6) medical conditions reported to increase TB risk.[8]

## Tuberculosis Education in Correctional Facilities

Recognizing the need to increase awareness of the TB/HIV problem and knowledge regarding prevention and control, CDC's tuberculosis division has developed some new educational materials for inmates and staff. These materials are being field tested and prepared for distribution.[9]

"Doing Time with TB" is a brochure for inmates which provides basic information on signs and symptoms of TB infection and disease, the link with HIV, and prevention measures. The brochure contains simple cartoons illustrating key prevention and treatment messages. It stresses that TB can be prevented and cured if one follows simple principles—e.g. "[a]nti-TB drugs only work when you take them;" "[i]t is very important that you take all of your medicine."[10]

CDC has also developed "Control of Tuberculosis in Correctional Facilities: A Guide for Health Care Workers and Other Staff." This is a much more extensive document than the inmates' brochure. It provides an introduction to tuberculosis infection and disease and emphasizes the TB-HIV link. The guide details recommended strategies for TB control in prisons and jails—surveillance, containment of spread, and assessment of control programs. There is a useful flow chart of TB screening, information on prophylactic and therapeutic drugs, sample forms, and a list of suggested further readings.[11]

## Endnotes

1. Dr. Robert Greifinger, Deputy Commissioner/Chief Medical Officer, New York State Department of Correctional Services, personal communication, January 1991.
2. Mary Hutton, "Why Control TB Now?," presentation at the 12th National Conference on Correctional Health Care, Lake Buena Vista, Florida, October 31, 1988.
3. "Prevention and Control of Tuberculosis in Correctional Institutions: Recommendations of the Advisory Committee for the Elimination of Tuberculosis," *MMWR* May 12, 1989; 38: 313-320, 325.
4. *Ibid.*
5. *Ibid.*
6. Dr. Robert Greifinger, Deputy Commissioner/Chief Medical Officer, New York State Department of Correctional Services, personal communication, January 1991.
7. Dr. Lawrence Mendel, Medical Director, Ohio Department of Rehabilitation and Correction, personal communication, January 1991.
8. "Screening for Tuberculosis and Tuberculous Infection in High-Risk Populations: Recommendations of the Advisory Committee for Elimination of Tuberculosis," *MMWR*, May 18, 1990; 39: No. RR-8.
9. Persons interested in obtaining these materials should contact Tuberculosis Division, Center for Prevention Services, Centers for Disease Control, Mail Stop E-10, 1600 Clifton Road, Atlanta, GA 30333.
10. CDC, "Doing Time with TB," draft, November 1990.
11. CDC, "Control of Tuberculosis in Correctional Facilities: A Guide for Health Care Workers and Other Staff," draft, November 1990.

# Chapter 4

# HIV Education and Training

Dr. Robert Greifinger, Deputy Commissioner/Chief Medical Officer for the New York State Department of Correctional Services, terms the HIV epidemic in correctional facilities a great "public health opportunity"[1] for clinicians, practitioners, advocates, and others. Because persons with histories of high-risk behavior are dramatically overrepresented in correctional institutions, these facilities literally provide "captive audiences" with a great need for training and education programs.

The need for intensified education is demonstrated by a recent study of HIV risk among intravenous drug users in New York City's Rikers Island facility. Researchers found that IDUs are still likely to engage in extremely risky behaviors: sharing needles, cookers, and rinse water continues to be common behavior. However, the researchers were encouraged to find that most IDUs no longer believe that cleaning shared works would be deemed an insult among friends and "running partners." Previously, such precautionary measures would have been considered an affront, particularly in a correctional environment where tensions and suspicions are already high. The study also found that condom use was "infrequent" among men and women. As the researchers note, the "implications of these findings for HIV transmission make it imperative to deliver better designed and more intensive AIDS education programs" within correctional facilities.[2]

HIV education *is* becoming more institutionalized within correctional facilities. This year's survey documents an increase in the number of facilities offering live education and training, as well as individual counseling. General awareness of transmission and high-risk behaviors has increased, both inside and outside the walls of correctional institutions, and some correctional systems report funding being specifically allocated by legislatures for HIV education staff and programs. Educational programs within prisons and jails are still almost exclusively provided by health services staff or outside professionals and advocates. Educational programs run by inmates are still scarce, despite the success of and attention accorded such programs as ACE (AIDS Counseling and Education) in New York. (This program, which has become a model for other inmate-oriented programs, is discussed in-depth below.) The need for education is clear, as suggested by the research findings on continuing high-risk behaviors referred to above. Unfortunately, there is still a great deal of myth and misinformation on HIV and related matters within correctional facilities.

## Concern among Inmates and Staff

NIJ survey results on inmate and staff concern about HIV/AIDS continue to be mixed, although, if anything, they suggest a stabilization in levels of such concern. Twenty-three percent of state and federal prison systems report that concern has increased among inmates, while the majority, 53 percent, report no change in inmate concern, and only 24 percent suggest that concern has receded. Among responding city/county jail systems, the pattern is similar: 23 percent report that concern among inmates has decreased, while 30 percent believe that it has increased, and about half of all jails, 48 percent, report inmate concern as having stayed the same in the past year. The vast majority of Canadian systems, 75 percent, believe that levels of inmate concern have remained essentially constant since last year. About half of the responding systems in all categories, moreover, estimate that staff concern about HIV has remained at similar levels as last year, with smaller percentages pointing to increases or decreases in staff concern.

It is important to note that these reported levels of concern reflect only the perceptions of one or, at most, several staff members responsible for responding to the survey. Generally, respondents may check with other staff in their facilities, but ultimately they report their own assessment as to the concern levels among staff. Estimates of inmate concern may be based on voluntary HIV testing activity,

interest in educational materials, attendance at training sessions, or informal conversations with prisoners.

The amount and type of litigation filed by inmates is indicative of the fear and stigma that still surrounds HIV/AIDS and the continuing need for education. Although inmates continue to file lawsuits seeking mandatory testing and segregation of HIV-seropositive inmates, the frequency of this type of litigation has declined somewhat. (Legal developments are detailed in Chapter 9.)

## Live Education and Training Sessions

Live training and education sessions should be the cornerstone of efforts to educate inmates and staff about the AIDS epidemic. However, the research literature clearly shows that simply providing information about HIV disease does not usually induce people to change their high-risk behaviors, which are often addictive and deeply entrenched. To help individuals initiate and maintain risk reduction, innovative and ongoing counseling and peer support strategies are necessary. Therefore, the ultimate goal ought to be comprehensive HIV prevention strategies comprising not only traditional "education" programs, but also peer-led sessions, support groups, individual counseling, and vastly expanded drug treatment opportunities.

As shown in Figure 11, virtually all U.S. State/Federal systems and Canadian systems provide live HIV education for inmates. About three-fourths of responding city/county jail systems have live educational programs for prisoners. The percentages of systems providing live education has increased in all three categories since 1989. Also increasing were the proportions of U.S. systems offering live sessions in *all* of their facilities. The 1989 NIJ survey found that only two-thirds of State/Federal facilities provided live education in *all* institutions. In 1990, 80 percent of State/Federal systems reported live education sessions in all facilities. Among responding city/county jail systems, the increase was from 48 percent to 56 percent. Fifty-eight percent of Canadian systems reported providing live education in all institutions, down slightly from 64 percent in 1989.

Despite the apparent increase in sessions, many inmates are still not being reached with live education on HIV. Only 33 percent of responding city/county jail systems report that half (or more) of their inmates received one hour of live education in the past year. On the State/Federal level, just over half of the systems (57 percent) report that half of their inmates received one hour of live education in the past year.

Part of the explanation for the incomplete coverage is that many systems do not require inmates to attend live HIV education sessions. Attendance is always mandatory for inmates in 51 percent of State/Federal systems, and only 11 percent of city/county jail systems, as shown in Figure 11. Education sessions for inmates are "sometimes mandatory" in 35 percent of State/Federal systems and 19 percent of city/county systems (see Figure 11). Systems in the "sometimes mandatory" category generally have required education sessions for incoming inmates, with any subsequent sessions attended on a voluntary basis. Unfortunately, as AIDS still carries a stigma, large numbers of inmates may not attend such yearly updates for fear of being labeled as high-risk or infected with HIV. Regular updates are essential as information changes and misinformation reasserts itself. Correctional administrators should, therefore, consider requiring attendance at update training, as well as intake sessions.

Typically, prison systems are better able to provide regular, mandatory, live education than jail systems, where turnover is extremely high and most types of programming are severely limited. However, facilities with high turnover offer opportunities to reach even more individuals with educational programs.

In addition to increases in live educational programs, the 1990 NIJ survey revealed increases in systems reportedly providing individual counseling to inmates on HIV-related issues. All State/Federal and responding city/county jail systems report offering at least some individual counseling, up from last year's figures of 90 percent and 84 percent, respectively. Individual counseling is provided by a wide array of professional and community services, including mental health practitioners (both internal and external to the system), chaplains, and community-based advocates.

Less widely available to correctional inmates are ongoing support groups for HIV-infected inmates and the "worried well" (conducted either by the inmates themselves or by counseling staff) and programs specifically designed for women. Several states have adopted programs to connect releasees with community-based organizations that will provide counseling, referrals, and information. However, this type of resource is limited. Most systems simply do not have the funds to allocate staff time for linking HIV-infected releasees with outside organizations. The few systems that do, however, have reported success with

**Figure 11**

**LIVE AIDS EDUCATION FOR INMATES, OCTOBER 1989 AND OCTOBER 1990[a]**

| | U.S. State/Federal Prison Systems | | | | U.S. City/County Jail Systems | | | | Canadian Systems | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | October 1989 (N=51) | | October 1990 (N=51) | | October 1989 (N=31) | | October 1990 (N=27) | | October 1989 (N=11) | | October 1990 (N=12) | |
| Live Education | Number of Systems | % | Number of Systems | % | Number of Systems | % | Number of Systems | % | Number of Systems | % | Number of Systems | % |
| Provided[b] | 46 | 90% | 49 | 96% | 21 | 68% | 20 | 74% | 9 | 82% | 11 | 92% |
| In All Institutions | 34 | 67 | 41 | 80 | 15 | 48 | 15 | 56 | 7 | 64 | 7 | 58 |
| Mandatory | 23 | 45 | 26 | 51 | 1 | 3 | 3 | 11 | 3 | 27 | 2 | 17 |
| Sometimes Voluntary and Sometimes Mandatory | 20 | 39 | 18 | 35 | 4 | 13 | 5 | 19 | 1 | 9 | 2 | 17 |
| Peer Education Programs | 7 | 14 | 11 | 22 | 0 | 0 | 4 | 15 | 0 | 0 | 0 | 0 |

[a]Live education involves the participation of a trained leader in some substantial part of a session.

[b]Includes programs in operation and under development.

*Source:* NIJ Questionnaire Responses.

inmates/clients following through with counseling once they are released.

## HIV Education for Staff

HIV education for correctional staff typically involves live training sessions during a new employee's orientation. As shown in Figure 12, virtually all responding correctional systems provide live HIV education for staff. Although these statistics are encouraging, they may be somewhat misleading. Training sessions are mandatory for staff in most prison and jail systems only during orientation. Educational updates, which are crucial given the changeability of information and perception regarding HIV, are mandatory for staff in only about half of U.S. systems. In Canada, educational sessions are mandatory for staff in only 17 percent of correctional systems.

The content of inmate and staff curricula should, if possible, be identical. Using different information or materials for the two audiences risks promotion of mistrust among either or both groups. It is important to avoid any suspicion that information is being withheld or that different messages are being presented to different people.[3] Notably, as shown in Figure 13, most systems' staff training

**Figure 12**

**LIVE AIDS EDUCATION FOR CORRECTIONAL STAFF, OCTOBER 1989 AND OCTOBER 1990[a]**

| | U.S. State/Federal Prison Systems | | | | U.S. City/County Jail Systems | | | | Canadian Systems | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | October 1989 (N=51) | | October 1990 (N=51) | | October 1989 (N=31) | | October 1990 (N=27) | | October 1989 (N=11) | | October 1990 (N=12) | |
| Live Education | Number of Systems | % | Number of Systems | % | Number of Systems | % | Number of Systems | % | Number of Systems | % | Number of Systems | % |
| Provided[b] | 48 | 94% | 50 | 98% | 24 | 77% | 26 | 96% | 10 | 91% | 11 | 92% |
| In All Institutions | 32 | 63 | 42 | 82 | 19 | 61 | 24 | 89 | 8 | 73 | 10 | 83 |
| Mandatory | 26 | 51 | 30 | 59 | 11 | 35 | 15 | 56 | 5 | 45 | 2 | 17 |
| Sometimes Voluntary and Sometimes Mandatory | 19 | 37 | 17 | 33 | 10 | 32 | 8 | 30 | 2 | 18 | 5 | 42 |

[a]Live education involves the participation of a trained leader in some substantial part of a session.
[b]Includes programs in operation and under development.
*Source*: NU Questionnaire Responses.

covers safer sex and needle cleaning procedures. This is important for several reasons. First, this makes it more possible for officers to be educators in the institution—bearing in mind, of course, the sensitivities inherent in staff advising inmates on the safer conduct of prohibited activity. Second, such education equips staff to reduce their own risk of acquiring HIV off the job.

The depth of staff training usually depends on the employee's level and frequency of contact with prisoners—line correctional officers and health-care providers typically receive more intensive training. Much staff training focuses on infection control procedures and incident response. It is important that such training also update information on transmission factors and the relative risk of specific situations and scenarios faced by staff. The CDC has published a curriculum on HIV prevention for emergency workers.[4]

The importance of ongoing, mandatory HIV education for staff, and the danger of not providing this training, is illustrated by the following story. One state reported a recent death by asphyxiation of an HIV-infected inmate who was being transferred—in four-point restraints—from one area of the prison to another. The correctional officers so feared that the inmate might spit on them, exposing them to HIV, that they stuffed a towel in his mouth, and he choked to death. This is a clear example of a death that might have been avoided had updated information on HIV risk factors been disseminated to all staff on a regular basis.

**Figure 13**

**AIDS EDUCATION IN CORRECTIONAL FACILITIES, OCTOBER 1990**

| Procedures | For Inmates | | | | | | For Staff | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | U.S. State/Federal Prison Systems (N=51) | | U.S. City/County Jail Systems (N=27) | | Canadian Systems (N=12) | | U.S. State/Federal Prison Systems (N=51) | | U.S. City/County Jail Systems (N=27) | | Canadian Systems (N=12) | |
| | Number of Systems | % | Number of Systems | % | Number of Systems | % | Number of Systems | % | Number of Systems | % | Number of Systems | % |
| Distribute Written Materials | 50 | 98% | 25 | 93% | 11 | 92% | 51 | 100% | 26 | 96% | 11 | 92% |
| Use Audio-Visual Materials | 48 | 94 | 20 | 74 | 10 | 83 | 50 | 98 | 26 | 96 | 10 | 83 |
| Topics Covered in Education Program: | | | | | | | | | | | | |
| Safe Sex Practices | 44 | 86 | 23 | 85 | 10 | 83 | 45 | 88 | 22 | 81 | 10 | 83 |
| Cleaning Techniques for Drug Injection Equipment | 31 | 61 | 18 | 67 | 6 | 50 | 28 | 55 | 17 | 63 | 6 | 50 |
| Spanish Language Education Available | 14 | 27 | 14 | 52 | — | — | 6 | 12 | 8 | 30 | — | — |
| Distribute Spanish Written Materials | 31 | 61 | 21 | 78 | — | — | 23 | 45 | 13 | 48 | — | — |
| Education for Individuals with Special Needs (e.g., hearing- or visually-impaired) | 12 | 24 | 11 | 41 | 1 | 8 | — | — | — | — | — | — |

*Source:* NIJ Questionnaire Responses.

## Content of Education Sessions

HIV education for inmates includes a spectrum of topics ranging from transmission, high-risk behaviors, testing, and the disease process. As noted above, staff education may stress infection control, but this should be covered in inmate training as well.

An increasing percentage of correctional systems in the United States and Canada now offer education and materials stressing needle cleaning and safer sex practices (e.g., the use of condoms and spermicides) as essential components of risk reduction. As noted above, however, many correctional officials are apprehensive about including information on cleaning works and using condoms since drug use and sex are prohibited in correctional facilities. Both activities clearly occur behind the walls, although their extent is a matter of dispute. As only a few specific behaviors can transmit HIV, and these behaviors are almost entirely within an individual's control, an emphasis on personalizing risk is very important.

## Peer Education and Support Programs

One educational strategy that is vastly underutilized in correctional settings, although considered to be highly promising, is use of inmate peer educators. For a variety of reasons, peer programs are particularly well-suited to provide HIV education in correctional facilities. Prisoner educators "speak the same language" as their audience, including frank and colloquial language, and bring credibility that educators from the "system" are hard-pressed to develop. Moreover, peer educators are more likely to be available to calm other prisoners in situations that may develop after normal working hours. According to Sharon Letts, who has developed a peer education program in the Delaware prison system, peer educators are "on site and available at all times." Letts stresses peer educators' abilities to "promote the use of compassionate behavior toward those who are HIV positive or who have AIDS." Peer educators can also "explain the lack of risk to other offenders through casual contact with greater credibility." Also, prisoners are more aware of the types of high-risk behavior that are occurring within their own institution. This enables them to "establish a free dialogue with the class participants" without the inmates fearing reprisal for admitting prohibited behaviors. The cost-effectiveness of peer education makes these programs even more appealing. The funding required to establish and maintain a peer program is very low when compared to what is required to set up an educational program that includes outside sources, professionals, and materials.[5]

Thus, peer-based programs offer some unique advantages for providing HIV education and support in prisons and jails. Inmate peer education programs on HIV have been employed with success in a number of correctional systems, including New York, Massachusetts, Delaware, and California. As shown in Figure 11, however, only 22 percent of U.S. State/Federal systems, 15 percent of responding city/county systems, and no Canadian systems reported having such programs.

Correctional administrators have a history of resistance to inmate initiatives based on a belief that support of such movements may lead to an erosion of institutional control. Some have also raised concerns that peer education programs will breach the confidentiality of HIV-infected inmate educators.[6] However, there are now several examples of inmate programs that have had highly beneficial effects for inmates, staff, and the overall atmosphere of the facilities. New York State correctional officials report that 16 of their facilities have active support group, counseling, and peer education programs with strong inmate involvement and administration support.[7]

### *ACE: An Exemplary Peer Education and Support Program for Women*

A perceived need for more active teaching strategies and increased involvement by HIV-infected inmates prompted women at New York's Bedford Hills Correctional Facility to initiate the ACE (AIDS Counseling and Education) program. The ACE program, conceived and managed by female inmates, clearly emphasizes inmate-to-inmate education, support, advocacy, and counseling. Although ACE counselors receive supervision and training from outside professionals, the inmates provide most of the HIV education and training within the facility themselves. This includes training for staff—perhaps the first time correctional inmates have ever provided training to correctional staff—which has been very well received.[8]

One of ACE's initial goals, in addition to providing support and counseling, was to work for improved housing conditions and recreational and vocational programs for inmates with HIV disease. Women with AIDS were segregated in the infirmary which was "dark, dirty [and] roach-infested...[with] sewage [that] occasionally backed up on the floors." Health-care providers in the institution, including physicians, were "afraid to have any contact with the AIDS patients." In a highly publicized incident, a

woman inmate died of AIDS after spending her last night alone in the infirmary without any contact with or visits from health-care staff, correctional officers, other inmates, family members, or anyone else.[9]

Thus, the ACE program grew out of a need to address such poor medical and environmental conditions, and, perhaps more importantly, to break down the "secrecy and denial, shame and fear, ignorance and ostracism" regarding HIV disease that pervaded Bedford Hills. As the creators of the program have stated, the "notion that prisoners can make a difference in a worldwide crisis is unimaginable to most authorities." Although it initially met with resistance, the ACE program now has the full support of administrators and the Department of Correctional Services. The program has been instrumental in improving conditions and engendering an atmosphere of trust and caring for prisoners with HIV in the facility.[10]

Offering programs in English and Spanish, ACE strives to "eliminate fear and stigma and promote safe behavior."[11] Support groups, attended by an average of 6 to 7 women, reflect the makeup of the prison population; there are blacks, Hispanics, Caribbeans, drug users, college graduates and high-school dropouts, gay and straight women, and inmates with and without HIV disease. Support groups are provided on a weekly basis, and other programs, including orientation sessions for all incoming inmates and seminars for those interested in becoming ACE counselors or buddies, are provided on a regular basis. ACE has also developed a prerelease program for inmates leaving the prison or out on furlough that includes referrals, information, advocacy groups, and support. The program has its own offices in the prison, where individual and group activities are conducted and a large resource library is maintained for inmates' use.

Although the ACE program faces continual challenges and obstacles, it has been most successful in its efforts to educate inmates on issues concerning HIV, raising standards of medical care for inmates with HIV disease, and developing an exemplary program of peer education. As such, ACE has been inundated with requests for information since its inception.[12] An ACE curriculum and manual are available, along with brochures and other information.[13]

ACE is also helping to fill a void in educational programs addressing the specific needs of women. Brenda Smith, Director of the Women in Prison Project of the National Women's Law Center argues that "first and foremost, women need information and education." Smith reports that women experience "an incredible amount of fear, denial, and guilt...about their risk of contracting the HIV virus and passing it on to their sexual partners or children." She strongly recommends racially and culturally sensitive programs for women that not only present basic information on HIV but also focus on helping women empower themselves and build self-esteem so they can address such issues as sexuality and safer sex, rape, incest, child abuse, domestic violence, and addiction.[14]

### *Peer Education Programs for Men*

Peer education and support programs have been initiated by male inmates in New York State, Massachusetts, and elsewhere. After serious and lengthy resistance from correctional officials, some of these programs are beginning to gain acceptance and momentum. Inmates in New York have produced some high quality materials on HIV disease.

One HIV-infected inmate has written an educational pamphlet entitled "Inmate to Inmate" that gives an overview of transmission, symptoms, testing procedures, and high-risk behaviors. Unlike so many educational materials distributed within prison and jail facilities, this pamphlet is clear, concise, readable, and, more importantly, specifically addresses the concerns of prisoners. It is particularly helpful for prisoners who have already been confirmed seropositive as it addresses questions such as "Can my being HIV+ affect my prison programs?"; "Who should I tell that I'm HIV+?"; and "How does being HIV+ affect my chances for parole?"[15] Questions and problems such as these are typically not addressed in materials distributed within correctional facilities.

Other inmate-oriented programs in New York State include the Health Action Crisis Committee (HACC) in Green Haven Correctional Facility and the Prisoners' Education Project on AIDS at Auburn Correctional Facility. HACC was formed by several male prisoners to cope with temporary release issues, medical and social treatment of inmates with AIDS, and the isolation experienced by inmates with HIV. At first, HACC met with strong resistance from prison officials. Finally, the group began to convince the administration that they were "prepared and [could]...create, in a time of need, peer...programs for education, counseling and care, with a holistic and pastoral approach."[16] Juan Rivera, one of the founding members of HACC notes that the ACE program provided not only inspiration but methodology as well. HACC is currently implementing a "buddy" program, similar to ACE's, that assists inmates with letter writing and access to infor-

mation and referrals and, most importantly, provides an "emotional release" to HIV infected prisoners.[17] Auburn's Prisoners Educational Project on AIDS (PEPA) also met with resistance from officials, including the transferring of most of the men involved in the project to other facilities. Indeed, as of December 1989, one of its founders declared that the program was "all but defunct."[18]

In December of 1989, prisoners at Massachusetts' Norfolk Correctional Institution launched a successful program of peer education that includes testing of knowledge and awareness of AIDS and AIDS-related issues, extensive counseling, lesson plans, referrals, and presentations from counselors. Topics covered by instructors include history and origin of HIV, definition of AIDS/HIV, transmission, symptoms, and the disease process. An "AIDS Education Workshop Program for Inmates by Inmates" is conducted both in English and Spanish by prisoners who have been trained and supervised, for a period of sixteen weeks, by the Department of Public Health and the Department of Correction's Health Services Division. The AIDS Education Workshop Program now has the full support of the administration, including the provision of two and a half days of "good time" to those who successfully complete the program. Members admit the number of inmates taking the course for good time can be fairly high, although those who complete the program nevertheless come out with a "better understanding of AIDS and HIV" as a result.[19]

MCI Norfolk is also the home of *Odyssey*, a prison publication that covers, among other topics, AIDS issues. In one of the first issues printed, *Odyssey* contained an interview with an HIV-infected inmate who stressed the need for educational programs, including peer programs, as "AIDS victims fear discrimination and moral condemnation. Because prisoners live in a closed environment...the fear, hysteria, and prejudice that exist within the larger community is magnified. Treatment within prison, therefore, will require a greater concentration of resources and a more comprehensive educational and therapeutic program."[20]

Although administration officials at MCI Norfolk initially were resistant to these attempts by inmates to educate themselves, the inmates at Norfolk prison—along with inmates in New York state prisons and other institutions around the country—have been successful in overcoming resistance and establishing effective peer education and support programs.

## Educational Materials and Videos

As shown in Figure 13, virtually all responding correctional systems employ written and audio-visual materials as part of their HIV education efforts. Clearly, a reliance on written materials is an inadequate approach. Whether viewed as the centerpiece of an educational strategy or an adjunct to it, written materials often fall short of delivering clear, cogent, and accessible messages on HIV. It is critical that such materials be prepared with sensitivity to the literacy levels, as well as the racial, ethnic and cultural composition of the target audience.

Peer educators and peer-generated materials, as noted, are likely to be sensitive to literacy and comprehension levels. The "Inmate to Inmate" brochure, for example, is written at a level that most inmates should be able to comprehend. Many written materials distributed by public health agencies, the American Red Cross, and community-based advocacy groups are appropriate for an audience with a minimum ninth grade reading level. However, in many inmate populations, average reading levels are between third and sixth grade.

Some materials have been designed for these lower reading levels.[21] However, many facilities cannot afford to purchase large quantities of these materials. Also, these materials often do not address the specific concerns of incarcerated individuals.

Some correctional systems have created their own materials based on the reading levels of their populations. In Jackson County (St. Louis), Missouri, for example, research was conducted to determine the average reading level of the population. Having determined it to be at the seventh grade level, all pamphlets and educational materials were rewritten for that level. Similarly, state correctional systems in Arkansas, Illinois, and Washington are either investigating possible discrepancies between the reading levels of inmates and the materials currently used or have already changed their materials to match inmate literacy levels.[22]

Some correctional systems have attempted to avoid the problems of literacy level by relying more on videos. Although most correctional facilities use only one or two videos, some states actively seek out new audio-visual material with up-to-date information.

Most HIV educational videos currently available are not effective in addressing the specific concern of prisoners. A notable exception is "Con to Con," a video produced by Georgia inmates. The paucity of good videos for prisoners

prompted Billy Jones, an ex-offender and longtime AIDS advocate, to develop "A Will to Live," a video that includes "ex-offenders, recovering addicts, former prostitutes, persons...involved in adverse behaviors." According to Jones, "A Will to Live" is intended to promote a very different message from that fostered by "AIDS: A Bad Way to Die." The latter, a video made by New York state inmates in 1986, focused on *dying* of AIDS, while Jones' work stresses *living* with HIV disease. It is critical, Jones states, to encourage hope rather than despair.[23]

Although videos can be a good means of disseminating information, particularly new videos that include accurate, updated information, they should not be considered an alternative to live presentations with active audience participation and dialogue. Instead, videos should be used to introduce or supplement more active forms of AIDS education.

## Spanish Language and Special Needs Programming

HIV education sessions conducted in Spanish are still quite scarce, despite the large population of Hispanic inmates in correctional facilities around the country. As shown in Figure 13, only 27 percent of State/Federal prison systems and 52 percent of responding city/county jail systems offer live sessions in Spanish. Spanish language materials—including written materials and videos—are available for inmates in 61 percent of prison systems and 78 percent of responding jail systems. Administrators should consider expanding the availability of Spanish language programs and materials. Programs in other languages should also be offered where warranted by inmate population characteristics.

Figure 13 reveals that only a quarter of State/Federal prison systems and less than half of responding city/county jail systems have HIV educational programs or materials in place for special needs inmates (e.g., those who are sight- or hearing-impaired). Many systems report never having encountered special needs prisoners. Some of these systems suggest that they would be able to assemble appropriate materials were the need to arise. However, HIV educational materials are readily obtainable for the hearing- and visually-impaired and should routinely be made available in correctional facilities. AIDS materials for the mentally-impaired are also available and should be accessible to inmates as well.

## Endnotes


1. Robert Greifinger, Testimony before the National Commission on AIDS, New York, August 16, 1990.
2. S. Magura, A. Rosenblum, and H. Joseph, "AIDS Risk among Intravenous Drug-Using Offenders" *Crime and Delinquency* 1991; 37: 86-98.
3. Interview with Dr. Dennis Kleinsasser, Director of Clinical Services, Colorado Department of Corrections, Colorado Springs, December 13, 1990.
4. A Curriculum Guide for Public Safety and Emergency-Response Workers. Atlanta, Georgia, February 1989.
5. Sharon Letts, Deputy Director, Delaware Council on Crime and Justice, Testimony before the National Commission on AIDS, New York, August 17, 1990.
6. Interview with medical and counseling staff, Fishkill Correctional Facility, New York, October 24, 1990.
7. Interview with Dr. Robert Greifinger, Fishkill Correctional Facility, New York, October 24, 1990.
8. Interviews with staff and inmate educators at ACE program, Bedford Hills, New York, October 25, 1990.
9. K. Boudin and J. Clark, "Community of Women Organize Themselves to Cope with the AIDS Crisis: A Case Study from Bedford Hills Correctional Facility," *Social Justice* 1990; 17: 90-107.
10. *Ibid.*
11. "Break through the Wall of Fear," (ACE Brochure), 1990.
12. "Bedford Hills' ACE Program Helping Eliminate Fear, Stigma," *AIDS Policy and Law* August 8, 1990, pp. 5-6.
13. These materials may be obtained by contacting the ACE Office, Bedford Hills Correctional Facility, Bedford Hills, New York 10507.
14. Brenda V. Smith, "Women in Prison and HIV Infection: Perspectives and Recommendations," Testimony before the National Commission on AIDS, p. 9.
15. "Inmate to Inmate," Inmate brochure, Fishkill Correctional Facility, New York, 1989.
16. Ruben Rodriguez, unpublished paper (1989), among prisoner materials submitted to the National Commission on AIDS, August, 1990.

17. Juan Rivera, "The Haven II", unpublished paper (1989), among prisoner materials submitted to the National Commission on AIDS, August 1990.

18. Mujahid Farid, "The Social Dimensions of AIDS in the Prisons," unpublished essay (December 1989) among prisoner materials submitted to the National Commission on AIDS, August 1990.

19. Interviews with inmates at MCI Norfolk Correctional Institution, January 15, 1991.

20. Luke Janus, "Interview on Death Row," *Odyssey* Fall 1990; pp. 38-40.

21. Including materials from the San Francisco AIDS Foundation (333 Valencia St., San Franciso, CA 94103) and "Scriptographic" booklets from Channing L. Bete Co., Inc. (S. Deerfield, Massachusetts 01373).

22. NIJ survey responses, 1990.

23. Billy Jones, Testimony Before the National Commission on AIDS, New York, August 17, 1990.

# Chapter 5

# HIV Precautionary Measures

One of the delicate balancing acts correctional officials undertake as they confront the HIV epidemic is the need to institute reasonable policies for the protection of staff and inmates from infection, while at the same time maintaining calm, avoiding extreme responses, and ensuring that the measures undertaken are consistent with the messages promoted by educational programs.

## Infection Control Based on Universal Precautions

An ongoing debate in the correctional response to HIV is whether correctional officers should know the antibody status of inmates with whom they work. Many officers believe that having such knowledge would better enable them to protect themselves from infection. Opponents of such disclosure emphasize both the importance of confidentiality and the potential danger in officers' basing their precautionary response on *thinking* they know who in the population is infected and who is not. Critics point out that because there is a lag between HIV infection and seroconversion detected by currently used antibody tests (the "window period") and new infections may occur during imprisonment, no testing and disclosure program can guarantee identification of all infected individuals. Thus, a false sense of security may be engendered. Moreover, in a system with numerous infected inmates, even if testing were foolproof, officers would not always be able to remember who is and who is not HIV seropositive.

The alternative to testing and notification which avoids some of these pitfalls is to base infection control policies on "universal precautions"—that is, treating everyone as if they are HIV-infected and avoiding unprotected contact with their blood, semen, and certain other fluids considered potentially infective. This is the approach generally taken by medical health care providers and institutions. In 1988, CDC issued revised guidelines stating that universal precautions were no longer necessary for contact with saliva, tears, sweat, vomitus, urine or feces, unless they contain visible blood.[1]

In 1989, CDC issued extensive guidelines for prevention of HIV transmission to health-care and emergency workers, including police and correctional officers. These guidelines stress universal precautions but note the need for their specific adaptation to the exigent situations faced by emergency, law enforcement, and correctional workers. The guidelines include procedures for body and cell searches, disposing of needles and sharp instruments, handwashing, cleaning up spills, and handling infectious waste. Recommendations for use of protective equipment such as gloves and CPR masks are also included.[2]

Many correctional systems have adopted detailed infection control policies and procedures, most based on universal precautions and the CDC guidelines. Such procedures, if faithfully implemented, will help to protect staff (and inmates, for that matter) not only from HIV, but also from hepatitis B and many other blood-borne and infectious diseases.

Implementation of infection control is not a matter of following a simple formula, however. As all correctional officers know, situations often arise quickly and unpredictably. An immediate response is necessary, and officers and other staff need to use their judgement and discretion as to when universal precautions should be employed. They should neither overreact nor place themselves at undue risk. This is not a simple task. Neither the CDC guidelines nor any set of policies can cover all contingencies. But they can provide some basic principles to guide response. For example, the CDC guidelines suggest that if it is impossible to clearly distinguish among body fluids in a situation, all should be treated as potentially infectious.[3]

The CDC guidelines also contain procedures to follow after an exposure has occurred. These include medical

protocols as well as procedures for carefully documenting the incident. Numerous correctional systems have adopted exposure response protocols. For example, the New York state system's policy defines "significant contacts" ("parenteral [needle sticks, lacerations, nonintact skin] or mucous membrane [eye, mouth] exposure to blood or semen") and details procedures to follow if such contacts occur. The major steps include "immediate definitive decontamination" of the site, review of the source's HIV/hepatitis B status (a test may be requested, but not required, of the source), referral for HIV counseling and testing, and discusssion of the option of zidovudine prophylactic treatment (noting that such treatment has not been proven effective in preventing infection).[4]

## Other Precautionary Measures

As the crisis atmosphere surrounding HIV/AIDS in correctional facilities has dissipated somewhat, there has been a concomitant decline in extreme and inappropriate precautionary measures. However, there remain some common policies which, while probably implemented in good faith, may be counterproductive in various ways.

A good example is the exclusion of HIV-infected prisoners from work assignments in food sevice. There is no record of HIV transmission through food or food service workers, and medical experts suggest that there is virtually no risk of this occurring. Yet, many correctional agencies bar HIV-infected inmates from food service jobs for fear that their appearance there would prompt unrest and threaten institutional security. Similarly, in many facilities, HIV-infected inmates are required to use disposable plates and silverware.

The problem with such policies is that they may undermine educational messages. If educational programs emphasize that HIV is not transmitted casually (including through contact with food), inmates and staff will wonder why HIV-infected prisoners are excluded from food service and why they must use disposable food service items. Another issue posed by such differential policies is that they may breach the confidentiality of HIV-infected prisoners.[5] These are complicated problems, but administrators should consider the various implications of policies in this regard.

## Availability of Condoms, Bleach and Needles

Another category of HIV precautionary measures involves methods of reducing the risk of infection in sexual contact and needle use. This is, of course, an extremely controversial area in corrections since sex and drug use are prohibited in institutions. The 1990 NIJ survey reveals no systems added to the list of those making condoms available to inmates in correctional facilities since 1989. Five systems continue to provide condoms to inmates: Mississippi, Vermont, New York City, San Francisco, and Philadelphia. In Canada, Quebec's Provincial correctional system plans to institute condom availability during 1991.[6] A number of systems reported that condom availability continued under discussion, but in none of these had the advocates been able to win agreement. Notably, while no new systems have instituted condom availability, none have dropped the policy either. Apparently, in these five systems condoms have not been used as weapons or to smuggle drugs, as some opponents of condom distribution had predicted.

In most instances, medical staff are the advocates of condom availability while correctional managers and security staff are opposed. This debate exemplifies the often sharply differing perspectives of these two groups. Health-care workers emphasize a public health model—that is, they recognize that sex occurs in prison[7] and take steps best calculated to prevent infection and disease—while correctional officials stress enforcement of regulations, the problem of appearing to condone prohibited behavior, and overall maintenance of security and institutional control. According to a distinguished panel that examined the New York State prison system's response to HIV, the conflict is "inevitable." The panel stated that "[d]elivering decent and appropriate health care in prison requires knowedgeable medical professionals to set rules that define medical responsibility and to negotiate the realistic implementation of those rules in the correctional setting."[8] Some correctional medical staff have apparently taken the initiative to implement what they considered appropriate public health measures even if this was prohibited by the correctional system. For example, Dr. German Maisonet, Chief of HIV Services at California's Correctional Medical Facility (Vacaville), openly testified to the National Commission on AIDS that he and other health care workers routinely distribute condoms to inmates.[9]

Opponents of condom distribution in prisons and jails often employ the "entering wedge" argument. That is, "if we allow condoms, why shouldn't we also allow bleach and clean needles?" The more compelling safety and security arguments against bleach and needles would seem to distinguish availability of these items from condom distribution. However, numerous correctional systems report openly discussing needle cleaning procedures in their educational programs, and inmates are reportedly able to obtain disinfectants and other compounds containing bleach that are commonly found in institutions.

Bleach for needle cleaning has been available in a number of Australian correctional systems for some time with no problems reported. Moreover, a recent national conference on HIV/AIDS in Australian prisons recommended that bleach distribution be expanded to all prisons and that a pilot needle exchange experiment be initiated in a correctional facility.[10]

## Endnotes


1. Centers for Disease Control, "Update: Universal Precautions for Prevention of Transmission of HIV, Hepatitis B Virus, and Other Blood-Borne Pathogens in Health-Care Settings," *MMWR* June 24, 1988; 37: 377-382.

2. CDC, "Guidelines for Prevention of Transmission of HIV and Hepatitis B Virus to Health-Care and Public-Safety Workers," *MMWR* June 23, 1989; 38: No. S-6.

3. *Ibid.*

4. New York State Department of Correctional Services, *Policies, Procedures and Guidelines Manual*, Health Section, Item #18, "HIV Exposure," March 26, 1990.

5. "Confidentiality Said Breached by Serving Food on Paper Plates," *AIDS Policy and Law*, December 12, 1990, p. 3.

6. NIJ survey response, 1990.

7. See, for example, K.H. Van Hoeven et al., "Evidence for Gonococcal Transmission within a Correctional System," *American Jornal of Public Health* December 1990; 80:1505-1506.

8. New York State Department of Health - AIDS Institute, AIDS Advisory Council, Ad hoc Committee on AIDS and Correctional Facilities, "Management of HIV Infection in New York State Prisons," November 1989, pp. 9-10.

9. "Prisons' Care Systems Swamped By AIDS Epidemic, Panel Told," *AIDS Policy and Law* September 5, 1990, p. 4.

10. Communique, AIDS/HIV and Prisons Conference, Melbourne, November 21, 1990.

# Chapter 6

# HIV Testing, Counseling, Confidentiality and Notification Policies

In the wider world, the discussion of HIV antibody testing seems to have shifted completely in the past few years from a debate over testing as a tool for preventing the spread of infection to a widespread acceptance of *voluntary* counseling and testing as an integral part of medical intervention. This is primarily a result of the discovery that early treatment with zidovudine (often called AZT) slows the progression to symptomatic HIV disease. In corrections, this shift has been less dramatic. In some systems, there is persistent support for *mandatory* testing as part of an infection control and/or early intervention strategy.

## HIV Testing Policies

### *Mandatory Mass Screening*

As shown in Figure 14, sixteen State prison systems and the Federal Bureau of Prisons report having mandatory mass screening for HIV among their inmates. (We define mandatory mass screening as any one or more of the following: mandatory identity-linked testing of all incoming inmates, all current inmates, or all inmates about to be released.) The 16 State systems screen all intakes (and may screen current and about-to-be-released prisoners, as well), while the Federal Bureau of Prisons screens all releasees and a 10 percent sample of each year's intakes. No responding city/county or Canadian systems have mass mandatory screening policies.

The 17 mass screening jurisdictions represent a gain of one since 1989; Rhode Island has joined the list. No systems reported discontinuing mass screening in 1990. While there has been no return to the sharp increase in mass screening jurisdictions seen between 1986 and 1987 (when the number jumped from 3 to 13), there has been a slow, but steady increase in systems adopting such policies since 1987. It is interesting to note that even as mass screening slowly spreads, segregation of HIV-seropositive inmates has continued to decline in favor (see Chapter 7). The result is that while 16 states have policies requiring all inmates to be screened for HIV antibody, only three of these states segregate all those found to be HIV-positive.

From the standpoint of prevention, the logic of mandatory screening without segregation is elusive. However, as will emerge below, some systems believe that mandatory testing is necessary to identify inmates for early medical intervention and ongoing clinical monitoring. In some other jurisdictions, mandatory testing (but not segregation) was legislatively imposed against the wishes of the correctional agency,[1] and the agency had no wish to extend policy beyond what it was required to do.

Comments regarding several of the jurisdictions on the current mass screening list should be added. In Idaho, mandatory mass screening of inmates is required by law, but the legislature has failed to appropriate sufficient funds to implement the program. The result is that while mass screening is the legal policy in Idaho prisons, it is not occurring in fact.[2] In another state, mass screening of inmates was also legislatively mandated, but medical staff in the institutions disagreed with the policy and have failed to implement it. HIV antibody testing in this state occurs on a voluntary basis only.

In Colorado, mass screening was ordered by the governor, a policy that is strongly supported by top correctional officials, including the Executive Director and Director of Clinical Services. Although studies in several states have shown that the majority of HIV-infected inmates and those at high risk for infection will come forward for voluntary testing, the Colorado officials believe that this would not occur in their system. Therefore, they consider it essential to test on a mandatory basis to identify all (or as many as

**Figure 14**

**CORRECTIONAL SYSTEMS CONDUCTING MANDATORY MASS SCREENING OF INMATES, OCTOBER 1990[a]**

| U.S. State/Federal Prison Systems (N=51) | U.S. City/County Jail Systems (N=27) | Canadian Systems (N=12) |
|---|---|---|
| Federal Bureau of Prisons | None | None |
| Alabama | | |
| Colorado | | |
| Georgia | | |
| Idaho | | |
| Iowa | | |
| Michigan | | |
| Mississippi | | |
| Missouri | | |
| Nebraska | | |
| Nevada | | |
| New Hampshire | | |
| North Dakota | | |
| Oklahoma | | |
| Rhode Island | | |
| Utah | | |
| Wyoming | | |

[a]Defined as *mandatory* HIV antibody testing, generally identity-linked, of all new inmates, all releasees, and/or all current inmates, regardless of whether they do or do not show clinical indications of HIV infection. In terms of correctional policy, this type of testing differs in purpose and method from blinded epidemiological studies. Blinded studies are anonymous (*not* identity-linked) screenings intended to assess seroprevalence rates in a particular population.

*Source*: NIJ Questionnaire Responses.

possible) of the HIV-infected inmates, so they can be placed on zidovudine and given intensive medical monitoring. This position is based both on the conviction that a correctional system has a moral obligation to identify inmates with a need for medical treatment on a timely basis and on the fear that failure to identify and treat such inmates could lead to later lawsuits. As discussed in Chapter 7, moreover, Colorado is one of the two states that has both mandatory testing and residential segregation of all HIV-infected prisoners. Colorado officials continue to believe that mandatory testing combined with residential segregation of prisoners found to engage in high-risk behaviors represents an important prevention measure.[3]

### *"Risk-Group" Screening*

The policy of attempting to identify and screen only individuals with histories of high-risk behavior has drastically declined in favor over the past few years. As shown in Figure 15, only five State/Federal systems and two responding city/county systems have such policies. Implementation of "risk-group" screening has been fraught with problems from the beginning, largely because of the difficulty of identifying all members of these groups. Reliance on self-reports is notoriously inadequate, and most compulsory methods of identifying persons with risk factors are also problematic.

**Figure 15**

**SUMMARY OF CORRECTIONAL POLICIES ON HIV ANTIBODY TESTING OF INMATES, OCTOBER 1990[a]**

| Testing Policies | U.S State/Federal Prison Systems (N=51) | | U.S. City/County Jail Systems (N=27) | | Canadian Systems (N=12) | |
|---|---|---|---|---|---|---|
| | Number of Systems | % | Number of Systems | % | Number of Systems | % |
| Mandatory Screening of: | | | | | | |
| All Incoming/New Inmates | 16 | 31% | 0 | 0% | 0 | 0% |
| All Current Inmates | 4 | 8 | 0 | 0 | 0 | 0 |
| Releasees | 5 | 10 | 0 | 0 | 0 | 0 |
| Screening of "High Risk Groups"[b] | 5 | 10 | 2 | 7 | 0 | 0 |
| Voluntary/Inmate Request Testing | 33 | 65 | 17 | 63 | 9 | 75 |
| Testing if Clinical Indications[c] | 46 | 90 | 23 | 85 | 8 | 67 |
| Testing if Involvement in Incident[d] | 33 | 65 | 14 | 52 | 6 | 50 |

[a]This table includes actual and planned policies. The categorization is *not* mutually exclusive.

[b]Testing identifiable inmates with histories of high-risk behavior (e.g., homosexuals and IDUs), regardless of whether they do or do not show clinical indications of HIV infection or AIDS.

[c]Clinical signs or symptoms of HIV infection or AIDS.

[d]Incident involving possibility of exposure to blood or certain body fluids.

*Source*: NIJ Questionnaire Responses.

### *Voluntary/On-Request Testing*

In view of the findings that early intervention with zidovudine can be effective, it is important that correctional systems make testing available on request to all inmates. In New York State, inmates may obtain testing on demand—that is, without having to convince medical staff that they have risk factors.[4] In view of the widespread knowledge of the efficacy of early intervention, it would seem that inmates with histories of high-risk behavior will seek testing. This supposition, of course, depends on having reasonable assurances that confidentiality will be maintained and that early intervention will, in fact, be available. In addition, inmates may be dissuaded from volunteering if they know they will be segregated if they test positive. Studies in Wisconsin and Oregon have shown that most HIV-infected inmates and those with risk factors for HIV will take advantage of voluntary testing programs.[5]

Despite the importance of on-request testing, the 1990 NIJ survey reveals that, for the second year in a row, the number of correctional systems with voluntary or on-request testing policies has actually declined slightly. This

was true in State/Federal, city/county, and Canadian systems. Only about two-thirds of U.S. systems offer testing on this basis. Three-quarters of Canadian systems have such policies (Figure 15). As suggested by Figure 16 (a hierarchically derived, mutually exclusive categorization of testing policies), a number of State/Federal systems have both mandatory and voluntary/on-request testing. In city/county systems and Canadian systems, those without on-request policies largely leave it to medical staff to advise testing in the presence of clinical indications. Of course, such indications may not appear until long after infection, so it would appear to be better to allow inmates to seek testing on their own initiative if they know they have risk factors.

### *"Routine" Testing*

In guidelines issued in August 1987, the Public Health Service (PHS) recommended "routine" counseling and testing for persons with histories of high-risk behavior.[6] Routine testing represents an intermediate point between testing only on the request of the individual and mandatory testing. It means that individuals will be tested unless they decline. A critical point, of course, is whether they are *told* that they will be tested unless they decline.

The August 1987 PHS recommendations urged correctional authorities to determine the best means for counseling and testing inmates at entry and discharge.[7] At least one correctional system has now proposed adopting routine HIV antibody testing of inmates. In a management plan for addressing HIV among North Carolina prison inmates, the Chief of Health Services for the State correctional department recommended routine testing of admissions. Inmates would be informed of the policy and "given clear opportunity to refuse." This opportunity would include informed consent. If consent were not obtained in writing, the test would not be performed.[8] Whether or not prisoners would feel pressured to consent to testing under such a policy would depend upon the specifics of its implementation and how the options were presented.

## Pre- and Post-Test Counseling

As noted in Chapter 4, all responding correctional systems report that individual HIV counseling is available to inmates. Obviously, however, availability does not necessarily ensure quality and sensitivity. Pre- and post-test counseling is a critical part of a correctional system's entire approach to HIV, and it therefore deserves careful attention.

Particularly where testing is done mandatorily or where large numbers of inmates are coming forward for testing, it may not be feasible to conduct individual pre-test counseling, which is desirable to protect confidentiality and to facilitate open discussion. Pre-test counseling offers an important opportunity to present HIV risk reduction messages when inmates are not preoccupied with receiving their test results.

Individual post-test counseling is essential, especially for those with positive results. Despite efforts to improve their methods of notifying seropositive inmates of their test results, there are still reported instances of highly insensitive notification by correctional officers and others. HIV-infected inmates have reported being casually told by an officer in a hallway or other common area: "By the way, you have AIDS."[9] There are also allegations of correctional systems failing to inform inmates of positive test results for long periods of time.[10]

Post-test counseling is as important for seronegatives as for seropositives. Those with negative tests, particularly if they have histories of risk behavior, must be clearly informed that their results do not represent a license to continue those behaviors with impunity.

## Confidentiality and Notification Policies

Confidentiality and notification of HIV status present difficult challenges to correctional systems. Preservation of confidentiality is important to preventing discrimination (and perhaps worse) against HIV-infected persons, yet, as is widely known, perfect confidentiality is probably impossible to maintain in correctional settings with their prolific "rumor mills." The situation is further complicated by several other factors: 1) the strong desire of many correctional officers and others in prisons and jails to know the HIV status of inmates, and 2) the belief of some correctional officials that they have an obligation to notify the sexual partners of HIV-infected inmates.

Figure 17 shows that very few correctional systems have official policies for notifying line correctional officers or sexual partners of prisoners' HIV status. Policy does not necessarily translate into practice, however. Staff and inmates in many institutions report that the identities of HIV-infected prisoners are widely known. In some cases, this is because the infected inmates themselves divulge their condition. In others, confidentiality is breached when unauthorized personnel gain access to records, conversations are overheard and passed along, and so forth.

**Figure 16**

**HIV ANTIBODY TESTING OF INMATES, MUTUALLY EXCLUSIVE CATEGORIZATION, OCTOBER 1990[a]**

| | U.S. State/Federal Prison Systems | | U.S. City/County Jail Systems | | Canadian Systems | |
|---|---|---|---|---|---|---|
| | October 1990 (N=51) | | October 1990 (N=27) | | October 1990 (N=12) | |
| Procedure | Number of Systems | % | Number of Systems | % | Number of Systems | % |
| Mandatory Mass Screening (all incoming inmates, current inmates and/ or inmates at release) | 17 | 33% | 0 | 0% | 0 | 0% |
| Voluntary/Inmate Request Testing | 22 | 43 | 17 | 63 | 9 | 75 |
| Testing if Clinical Indications[b] | 12 | 24 | 9 | 33 | 3 | 25 |
| Other | 0 | 0 | 1 | 4 | 0 | 0 |
| Total | 51 | 100% | 27 | 100% | 12 | 100% |

[a]Includes actual and planned policies. This is a *hierarchical* categorization. That is, jurisdictions that do mass screening are placed in that category, regardless of whether they also do testing for other purposes; jurisdictions that screen identifiable inmates with histories of high-risk behaviors, but do no mass screening, are placed in the "screening of high-risk groups" category regardless of whether they also do testing for diagnosis, incident involvement, or epidemiologic studies, and so on.

[b]In this table, clinical indications includes lowered CD4 (T4) counts, opportunistic infections, and TB positivity or active TB.

*Source:* NIJ Questionnaire Responses.

**Figure 17**

**POLICIES REGARDING DISCLOSURE/NOTIFICATION OF INMATES' HIV ANTIBODY TEST RESULTS, OCTOBER 1990[a]**

| Parties to be notified during incarceration and/or at release according to policy[a] | U.S. State/Federal Prison Systems (N=51) | | U.S. City/County Jail Systems (N=27) | | Canadian Systems (N=12) | |
|---|---|---|---|---|---|---|
| | Number of Systems | % | Number of Systems | % | Number of Systems | % |
| Inmate | 51 | 100% | 27 | 100% | 12 | 100% |
| Attending Physician or Health-Care Worker | 51 | 100 | 25 | 93 | 11 | 92 |
| Other Medical Staff (community or correctional) | 30 | 59 | 13 | 48 | 5 | 42 |
| Correctional Management—Central Office | 29 | 57 | 8 | 30 | 5 | 42 |
| Correctional Management—Institution | 33 | 65 | 10 | 37 | 3 | 25 |
| Correctional Officers (security) | 7 | 14 | 6 | 22 | 2 | 17 |
| Public Health Department | 44 | 86 | 19 | 70 | 5 | 42 |
| Spouse/Sexual Partner(s) | 8 | 16 | 1 | 4 | 2 | 17 |
| Victims of Inmate (in community and/or in prison/jail) | 8 | 16 | 4 | 15 | 0 | 0 |
| Parole Agency | 17 | 33 | 2 | 7 | 2 | 17 |
| Residential Placement[b] | 4 | 8 | 3 | 11 | 1 | 8 |
| Work Placement[b] | 3 | 6 | 2 | 7 | 1 | 8 |
| Other:[c] | 2 | 4 | 2 | 7 | 1 | 8 |

[a]Figures include both systems which specified the conditions under which disclosure/notification to certain parties could be made (e.g., only with inmate consent and/or on a "need-to-know" basis) and systems which did not specify these conditions.

[b]Most systems view notification of residential or work placements as falling in the domain of parole agencies/divisions.

[c]This category includes public agencies, courts and other parties unspecified by responding systems.

*Source*: NIJ Questionnaire Responses.

In these circumstances, correctional systems strive to do the best possible job to preserve confidentiality and prevent unauthorized disclosure. A key first step is to have sound and detailed confidentiality policies regarding HIV-related information. These should not be based on vague "need-to-know" formulations because in prisons and jails virtually *everyone* thinks they have a need-to-know. Rather, policies should spell out *who* has such a need and in *what specific circumstances*.

Several states have passed laws regarding confidentiality/disclosure of prisoners' HIV test results. Some of these are extremely vague—for example, providing that correctional "personnel" (otherwise undefined) be notified if any prisoner is diagnosed with a contagious infectious disease. Other state laws continue to rely on less than fully defined applications of the "need-to-know" concept.[11]

By contrast, the New York State correctional system's policy on release of HIV/AIDS information is quite well defined. It begins with the premise, required by State law, that there is to be *no* disclosure of HIV status other than to the patient, without his or her written authorization. The policy then makes some well-defined exceptions to this premise for inmates. First, it provides that information can be released pursuant to a court order but not to a subpoena. Second, it lists individuals who may receive information without a written release from the inmate. These include the inmate's health-care provider, certain officials in the department's divisions of health services and mental health, attorneys for the correctional department, the Assistant Commissioner for Population Management "as necessary," parole officers "via the Health Discharge Summary Sheet," "authorized" employees of the State Commission of Correction (a watchdog agency), and funeral directors taking charge of the remains of deceased inmates. In addition, a very small number of individuals at the institutional level are authorized access, and this is carefully limited by the policy. The medical director and superintendent of the inmate's facility may be informed. However, the superintendent can only receive the information if he or she needs it to make a decision regarding the specific inmate. Such decisions are to be made by the superintendent "personally." Notably, line correctional officers and other institutional security staff are absent from this list.[12]

Thus, the New York policy is quite precise in its enumeration of permitted disclosures. Moreover, practical arrangements for testing and record keeping help to preserve confidentiality. According to the system's Chief Medical Officer, all HIV testing of inmates is performed by the state health department, rather than the correctional department. Indeed, no one outside of the correctional department's health services division is even informed as to the number of inmate tests done. No reference is made to HIV in inmates' program files, and access to medical files is strictly limited to medical and dental staff.[13]

California's Proposition 96, passed in 1988, requires disclosure of the names of inmates with, or suspected of having, communicable diseases to the correctional officials charged with their supervision. Most county jails in California have implemented the provision, but the American Civil Liberties Union is seeking to halt implementation of reporting in San Francisco on the grounds that it violates the privacy clause of the state constitution, the 4th Amendment's protection against unlawful searches and seizures, and the Rehabilitation Act's ban on discrimination against persons with disabilities. The case is awaiting trial on the ACLU's application for a permanent injunction.[14]

Notification of sexual partners raises complex issues for correctional officials. On the one hand, confidentiality is important and, indeed, in many jurisdictions, unauthorized disclosures of HIV status are prohibited by law. On the other hand, a number of correctional officials conscientiously believe that inmates will not be responsible about informing their sexual partners and that authorities who are in possession of the information should ensure that notification occurs. Officials are also clearly concerned about possible litigation should they fail to inform a sexual partner who is later infected by a released inmate.

Few systems have policies explicitly providing for disclosure by correctional officials to inmates' sexual partners, as shown in Figure 17. Most have adopted the CDC's recommendations for health-care workers: that HIV-infected persons be strongly counseled to notify their sexual partners, but that the health-care provider only carry out the notification if the patient refuses to do so.[15]

A small number of systems, including the Federal Bureau of Prisons, have gone beyond this model. The Bureau's policy is that all inmates be tested for HIV antibodies prior to release—whether at the end of their sentence or prior to their transfer to a community-based early release program. It has been alleged that the Bureau has delayed the release of prisoners who refuse to submit to HIV testing or whose HIV test results are not on file.[16] The Bureau has disputed these allegations. But the Bureau openly avows a policy of requiring not only testing but also notification of HIV status to sexual partners before an inmate may be granted participation in early release or furlough programs. According to Bureau Director Michael Quinlan, officials verify the notification by listening to the inmate's tele-

phone conversation with his or her sexual partner, by being present at a face-to-face meeting in which disclosure is made, or by placing a followup call to the sexual partner. If the inmate fails to notify the sexual partner, a Bureau official will make the notification. No HIV-positive inmate is permitted to participate in community release programs without verification that the sexual partner has been notified. Quinlan has stated that the policy is based on a belief that the Bureau has a "higher obligation [than agencies making policy for persons outside of prison] to make sure that the inmate does not act irresponsibly."[17]

Such policies raise the question of whether, and to what extent, prisoners should be subjected to different HIV-related policies from those applied to persons in the free world. Clearly, prisoners forfeit certain rights by being incarcerated. But HIV infection is not a crime and is, in almost every case, unrelated to the crime for which the inmate has been sentenced. The question thus becomes: Should correctional authorities, based on the fact that they possess information about HIV status and the belief that inmates as a group will not reliably inform their sexual partners of that status, impose more intrusive notification policies on prisoners?

## Endnotes

1. In previous NIJ surveys, 60 percent of state correctional systems reported receiving pressure from governors, legislatures, the media, or the public to institute mandatory mass screening of inmates. T. Hammett, *AIDS in Correctional Facilities: Issues and Options*, (3rd ed., Washington, D.C., National Institute of Justice, 1988), p. 59.

2. *Hays v. Idaho Department of Corrections* (Idaho District Court, 4th Judicial District) No. HC 2799, September 29, 1989.

3. Interview with Frank Gunter (Executive Director), Dennis Kleinsasser (Director of Clinical Services), and R.T. Moore (Associate Director of Clinical Services), Colorado Department of Corrections, Colorado Springs, December 13, 1990.

4. New York State Department of Correctional Services, *Policies, Procedures and Guidelines Manual*, Health Section, Item #70, "HIV Testing and Counseling," May 23, 1990.

5. N.J. Hoxie et al., "HIV Seroprevalence and the Acceptance of Voluntary HIV Testing Among Newly Incarcerated Male Prison Inmates in Wisconsin," *American Journal of Public Health* September 1990; 80: 1129-1131; J. Andros et al., "HIV Testing in Prisoners: Is Mandatory Testing Mandatory?" *American Journal of Public Health* July 1989; 79: 840-842.

6. "Public Health Service Guidelines for Counseling and Antibody Testing to Prevent HIV Infection and AIDS," *MMWR* August 14, 1987; 36: 509-515.

7. *Ibid.*

8. Parker Eales, "Management Plan for the Surveillance, Prevention, Control and Treatment of HIV Infection and AIDS in the North Carolina Department of Correction," legislatively mandated report, May 15, 1990, Recommendation No. 1.

9. Interviews with inmates at Fishkill Correctional Facility, New York, October 24, 1990, and Territorial Prison, Canon City, Colorado December 14, 1990.

10. NIJ survey response, 1990.

11. B.A. Belbot and R.V. del Carmen, "AIDS in Prisons: Legal Issues," *Crime and Delinquency* January 1991; 37: 139.

12. New York State Department of Correctional Services, *Policies Procedures and Guidelines Manual*, Records Section, Item #71, "Release of AIDS/HIV Information," May 23, 1990.

13. Interview with Dr. Robert Greifinger, Fishkill Correctional Facility, New York, October 24, 1990.

14. *Capaldini v. Hennessey*, CA App. Ct., 1st Dist., No. A052533, February 11, 1991; "ACLU is Granted Emergency Stay on Reporting Status of Inmates," *AIDS Policy and Law* February 20, 1991, pp. 2-3; Lt. Jan Dempsey, San Francisco Sheriff's Department, personal communication, March 14, 1991.

15. "Public Health Service Guidelines for Counseling and Antibody Testing to Prevent HIV Infection and AIDS," *MMWR* August 14, 1987; 36: 509-515.

16. Adam Starchild, "AIDS Testing Problems in Federal Prisons," undated paper submitted to the National Commission on AIDS, July 1990.

17. J. Michael Quinlan, "The Federal Prisons' Management Response to AIDS," in *AIDS and the Courts*, eds. C. Abt and K.M. Hardy (Cambridge: Abt, 1990), p. 95, 107.

# Chapter 7

# Housing and Correctional Management of Inmates with HIV Disease

For several years, correctional systems have been moving away from policies calling for blanket segregation, both residential and programmatic, of inmates with HIV disease. More and more, these inmates are being housed in general population and participating in the same programs and activities as general population prisoners. By and large, this integration (or, where segregation had been the rule, reintegration) has taken place without serious incident. Meanwhile, issues of early release and discharge planning for prisoners with HIV disease are confronting correctional systems and, in some cases, parole authorities and the courts with complex challenges.

## The Continuing Trend to Residential and Programmatic Integration

Figures 18 and 19 show the diminishing number of correctional systems with blanket segregation policies for HIV-infected prisoners and the increased numbers that presumptively "mainstream" such prisoners (i.e. place them in general population) or manage them on a case-by-case basis. Figure 18 shows that 29 percent of State/Federal prison systems now mainstream inmates with AIDS diagnoses, and 47 percent make housing decisions for them on a case-by-case basis. Only nine State/Federal systems (18 percent) permanently segregate or separate prisoners with AIDS, down from 16 in 1989. Almost three-fourths of State/Federal systems mainstream prisoners with asymptomatic HIV infection, and another 14 percent make decisions on a case-by-case basis. Similar policy breakdowns are revealed for city/county systems, with Canadian systems relying even more heavily on a case-by-case approach. In U.S. correctional systems the movement away from blanket segregation was initially toward case-by-case approaches and, in the past several years, toward presumptive general population housing.

Only four state systems in the U.S. currently segregate all known HIV-infected prisoners: Alabama, California, Colorado, and Mississippi. Pursuant to the settlement of a lawsuit, California has instituted a pilot program for the programmatic integration of some HIV-infected prisoners and, as discussed below, Colorado is gradually moving toward residential and programmatic integration. Only two responding U.S. city/county jail systems segregate all known HIV-infected prisoners.

Figure 19 shows the shifts in housing policies over time. In 1985, 42 percent of State/Federal systems had policies calling for segregation of at least some HIV-infected inmates, while 35 percent had presumptive general population or case-by-case policies. By 1990, these percentages had changed to 18 percent and 78 percent respectively. Almost 60 percent of responding city/county systems had segregation policies in 1985, while only 30 percent had mainstreaming or case-by-case policies. As of 1990, this breakdown had shifted to 7 percent and 89 percent. The Canadian systems, who were first surveyed in 1987, were already less reliant on segregation policies and this trend has continued.

Case-by-case and presumptive general population housing policies generally make it possible for inmates with HIV to be placed in the least restrictive situation commensurate with their normal security classification. In most cases, this permits them to engage in a full range of programs and activities in the institution. If their medical condition warrants, they can be hospitalized or, if they present behavioral or security problems, they can be administratively segregated. However, the vast majority of HIV-infected inmates do not require any continuous separate housing.

As research in the free world shows, when persons with HIV disease can lead their lives as normally as possible

**Figure 18**

**HOUSING POLICIES FOR INMATES WITH AIDS, ARC, AND ASYMPTOMATIC HIV INFECTION, OCTOBER 1990[a]**

| Housing Policy | U.S. State/Federal Prison Systems (N=51) | | | | | | U.S. City/County Jail Systems (N=27) | | | | | | Canadian Systems (N=12) | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | AIDS | | ARC[b] | | Asymptomatic HIV Infection | | AIDS | | ARC[b] | | Asymptomatic HIV Infection | | AIDS | | ARC[b] | | Asymptomatic HIV Infection | |
| | Number of Systems | % | Number of Systems | % | Number of Systems | % | Number of Systems | % | Number of Systems | % | Number of Systems | % | Number of Systems | % | Number of Systems | % | Number of Systems | % |
| All Remain in General Population with *No* Restrictions | 15 | 29% | 25 | 49% | 38 | 74% | 7 | 26% | 13 | 48% | 17 | 63% | 2 | 17% | 4 | 33% | 5 | 42% |
| All Remain in General Population with Restrictions/Precautionary Measures[c,d] | 1 | 2 | 3 | 6 | 1 | 2 | 0 | 0 | 1 | 4 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 8 |
| All Permanently Separated/ Segregated[e] | 9 | 18 | 5 | 10 | 4 | 8 | 4 | 15 | 3 | 11 | 2 | 7 | 1 | 8 | 1 | 8 | 1 | 8 |
| Case-by-Case Determination (based on medical and/or security or unspecified reasons) | 24 | 47 | 15 | 29 | 7 | 14 | 15 | 56 | 9 | 33 | 7 | 26 | 8 | 67 | 7 | 58 | 5 | 42 |
| No Policy/Policy Unknown | 2 | 4 | 3 | 6 | 1 | 2 | 1 | 4 | 1 | 4 | 1 | 4 | 1 | 8 | 0 | 0 | 0 | 0 |
| Total | 51 | 100% | 51 | 100% | 51 | 100% | 27 | 101%[f] | 27 | 100% | 27 | 100% | 12 | 100% | 12 | 99%[f] | 12 | 100% |

[a]These figures include hypothetical policies in jurisdictions that to date have no cases in a particular category. This categorization is mutually exclusive.

[b]The category ARC is no longer used by some correctional systems. This year's NIJ Survey presented the category as "ARC or a lesser form of *symptomatic* HIV disease."

[c]The figures in this category *include* systems who hospitalize a patient during severe illness but upon improvement return the inmate to general population.

[d]This category includes single-celling.

[e]This category includes *presumptive* hospitalization, infirmary housing, and administrative separation in medical or non-medical units.

[f]Due to rounding.

*Source*: NIJ Questionnaire Responses.

**Figure 19**

**COMBINATIONS OF HOUSING POLICIES FOR INMATES WITH AIDS, ARC, AND ASYMPTOMATIC HIV INFECTION, NOVEMBER 1985 AND OCTOBER 1990[a]**

| | U.S. State/Federal Prison Systems | | | | U.S. City/County Prison Systems | | | | Canadian Systems | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | November 1985 (N=51) | | October 1990 (N=51) | | November 1985 (N=33) | | October 1990 (N=27) | | October 1987[b] (N=12) | | October 1990 (N=12) | |
| Housing Policy Combination | Number of Systems | % | Number of Systems | % | Number of Systems | % | Number of Systems | % | Number of Systems | % | Number of Systems | % |
| Separate/Segregate AIDS Cases; ARC Cases and Asymptomatics Maintained in General Population | 3 | 6% | 5 | 10% | 3 | 9% | 0 | 0% | 0 | 0% | 0 | 0% |
| Separate/Segregate AIDS and ARC Cases; Asymptomatics Maintained in General Population | 10 | 20 | 0 | 0 | 3 | 9 | 0 | 0 | 0 | 0 | 0 | 0 |
| Separate/Segregate All Three Categories | 8 | 16 | 4 | 8 | 13 | 39 | 2 | 7 | 3 | 25 | 0 | 0 |
| No Separation/Segregation of Any Category | 2 | 4 | 16 | 31 | 0 | 0 | 7 | 26 | 0 | 0 | 2 | 17 |
| Combinations Involving Case-by-Case Determination (for at least one category) | 16 | 31 | 24 | 47 | 10 | 30 | 17 | 63 | 9 | 75 | 9 | 75 |
| Other Policy Combinations, No Policy, or Policy Unknown | 12 | 24 | 2 | 4 | 4 | 12 | 1 | 4 | 0 | 0 | 1 | 8 |
| Total | 51 | 101%[c] | 51 | 100% | 33 | 99%[c] | 27 | 100% | 12 | 100% | 12 | 100% |

[a]In this categorization, "separate/segregate" means that the basic policy is to hospitalize or administratively segregate, regardless of whether clinically ill inmates are returned to general population when their symptoms subside. This categorization is mutually exclusive.

[b]October 1987 was the first year Canadian systems were included in the NIJ survey.

[c]Due to rounding.

*Source*: NIJ Questionnaire Responses.

and are fully integrated with their peers, they are better able to maintain psychological and physiological well-being. This argument applies to prisoners as well. Most medical authorities agree with the Chief of HIV Services at California's Vacaville medical facility that "there is no medical,...rational or scientific basis for the segregation of inmates who are HIV positive."[1]

As noted, a few correctional systems continue to segregate all known HIV-infected inmates. Alabama maintains a strict segregation policy. At first, HIV-infected prisoners in Alabama were subjected to total isolation and had no access to any programs or activities. After a class-action lawsuit was filed against Alabama's policies, many of the worst aspects of the segregation policy were improved. However, the basic policy remains: all known HIV-infected prisoners are residentially and programmatically segregated for as long as they stay in the system. Alabama's policy of mandatory mass screening and segregation has been upheld in federal court,[2] but the decision is currently on appeal to the Eleventh Circuit. The lead attorney for the plaintiffs in the challenge to the Alabama policy believes that there was serious reversible error in the federal court's decision.[3]

## *Colorado: A Case Study of Integration*

Colorado offers an interesting case study of a state correctional system moving away from a blanket segregation policy toward integration of HIV-infected prisoners.[4] Like Alabama's, Colorado's policy of mandatory HIV screening and segregation was recently upheld in federal court.[5] Unlike Alabama, however, Colorado has been gradually implementing programmatic integration while maintaining, at least for the time being, residential segregation.

In Colorado, male HIV-infected prisoners live in Cell House 3 at Territorial Prison, a medium security facility in Canon City. Female HIV-infected inmates are not segregated in Colorado. The segregation of males had been total—that is, they had no access to programs or activities with general population. Some programs were offered in the segregated unit, but these were quite limited.

About a year ago, Colorado began to allow inmates from Cell House 3 to participate in certain programs in general population. The department has been careful to integrate the HIV-infected inmates gradually, in order to minimize the possibility that they would be intimidated or victimized. Indeed, officials report, there were some threats of violence, but no incidents actually occurred.

The integration process in Colorado has been accompanied by extensive HIV education for inmates and staff. Each type of program or activity was also integrated in a stepwise fashion. For example, HIV-infected prisoners were permitted to use the general population's visiting room during normal visiting times, but at first they were required to use a special area in the room. The special area was subsequently phased out so that total integration of visiting is now the practice. Similarly, when the HIV-infected prisoners were first given access to the institution's gymnasium, they had to use a separate weight stack. After a fairly short time, the weights used by the HIV-infected inmates and those used by the general population prisoners were intermingled. Then, for a time, some of the general population prisoners used a bleach solution to wipe down the equipment before they used it. Finally, this practice gradually ended, so that all equipment is shared and no unnecessary precautions are taken before their use. In the same way, inmates from Cell House 3 were gradually introduced into sick call line, the line to receive medications, the library and law library, educational programs, and work assignments. As of December 1990, there was total program integration.

Colorado officials believe that residential integration of HIV-infected inmates will also come. But they intend to proceed cautiously. They believe that there will not be dispersion of inmates with HIV disease throughout the correctional system. Instead, these inmates will likely be mainstreamed at Territorial or other facilities in Canon City, depending on their security classification. The correctional officials believe that keeping all HIV-infected inmates in one institutional complex enables the department to provide better medical care by concentrating limited expert staff. It would probably not be possible, under current budget constraints, to have a medical team well trained in the care of persons with HIV at every institution.

In addition, the officials in Colorado do not believe that all HIV-infected prisoners should be mainstreamed. First, they argue, some will prefer to remain in separate housing. This was confirmed by inmates in Cell House 3. They reported that some of the inmates would prefer to stay in the special unit. They are influenced by several factors. Some feel that there are advantages to being in the separate unit (e.g. shorter lines for the showers); others fear that they would be mistreated in population; and still others (those classified as maximum security) realize that mainstreaming would mean leaving the medium security Territorial Prison and going to a more secure facility. On the other hand, Cell House 3 inmates stated that most of

the HIV-infected prisoners would prefer to be in general population. "You can't just sit in the cell house and stay sane," one said, "you need to be in population to progress" in terms of lowering one's security classification and accumulating "good time" as rapidly as possible.[6]

Secondly, Colorado correctional authorities believe that it will still be necessary to segregate those HIV-infected prisoners who engage in high-risk behaviors. They argue that a correctional agency has a moral and legal obligation to minimize the occurrence of any behavior by which HIV may be transmitted. Colorado officials reject the policy option in which only predatory inmates are segregated and the problem of consensual activity is addressed—as it is outside the walls—by education and assumption of risk. They contend that it is impossible to distinguish clearly between consensual and non-consensual activity in a prison setting and that education simply does not work as well with prisoners as with people in the community.[7]

The arguments for integration and against blanket segregation of HIV-infected prisoners are compelling. However, the Colorado case for a gradual and more limited integration also raises important considerations. Ultimately, correctional authorities must use their best judgement to resolve these difficult issues and settle on policies and implementation strategies that are most fair to all concerned.

## Early and Compassionate Release of Inmates with HIV Disease

Prisoners in the advanced stages of AIDS are unlikely to pose a threat to the community. Most are seriously ill and unable to commit violent or other criminal acts, even if they wished to do so. Therefore, a strong argument can be made for granting such individuals early or compassionate release from prison. Cathy Potler, director of the AIDS in Prison project at the Correctional Association of New York, a private advocacy group, makes three major points in support of early release for prisoners with AIDS and other terminal illnesses. First, these prisoners should have time with their families before they die. Second, they may be able to receive superior services in the community than in prison. Finally, their early release will save correctional departments significant expenditures for security and medical care.[8]

Despite the strong case for early release, relatively few correctional systems have granted early release to prisoners with AIDS. The 1990 NIJ survey reveals that just over one-third (39 percent) of State/Federal systems, less than half (41 percent) of responding city/county jail systems, and one-third of Canadian systems have compassionate release programs for prisoners with AIDS. The Correctional Association of New York conducted a telephone survey of seven correctional systems with large numbers of AIDS cases (California, Florida, New Jersey, New York, Texas, Federal Bureau of Prisons, and New York City) and found that only one—New York City—had an early release program for the terminally ill that had been actively used to identify and release inmates with AIDS who do not pose a threat to the community. Under this program, approximately 125 inmates with AIDS have been released. Legislation passed in Connecticut in 1990 permits release of terminally ill prisoners deemed to pose no risk to the community. A number of prisoners with AIDS have already been released under the terms of this law.

Legislation permitting compassionate release of New York State prisoners with AIDS has been defeated several times in the legislature despite the support of Governor Cuomo. According to Potler, these defeats have been due to the "Willie Horton" issue—that is, many legislators simply are afraid to support early release of any prisoners.[9] In Colorado, compassionate release has been granted to prisoners with AIDS deemed not to pose a danger to the community.[10]

Besides compassionate release, there are several options for securing the release of prisoners with AIDS. However, these have rarely been used. Executive clemency, the Correctional Association survey found, has been employed only in a small number of cases in New York, Texas and New Jersey. In January 1991, New York Governor Mario Cuomo granted clemency to a prisoner on the basis of AIDS for the first time.[11] Also in New York State, numerous inmates with AIDS have been quietly granted "temporary release," enabling them to be transferred from prisons to hospitals in the community.[12] Statutory provisions allowing judges to resentence offenders have been used to release a few inmates with AIDS in California by reducing their sentences to time served. Colorado correctional officials state that they try not to let anyone die of AIDS in prison. Terminal inmates are typically transferred to a secure ward at the state hospital in Pueblo.[13]

Cathy Potler's arguments for early release include the point that it will save correctional systems the costs of the inmates' security and medical care. She also recommends that "no one should be released without an adequate discharge plan."[14] The dilemma posed by these two points is discussed in the next section.

## Discharge Planning

The significant cost savings available to correctional systems by releasing inmates with AIDS are no doubt seductive to administrators facing serious budgetary constraints. The problem is that releases motivated solely by the desire to cut costs either simply shift the cost burden to other government programs or result in patients receiving inadequate care in the community. Indeed, there is a real danger that inmates released without careful discharge planning will be unable to find adequate care and support in the community, particularly if they have no family or others to assist them.

In many areas of the country, medical services for the poor are strained to the breaking point. Moreover, many hospice and other programs in the community are not open to ex-prisoners. Ironically, it is true that a person with AIDS can sometimes obtain better care in prison than in the community. It has been suggested that ex-prisoners with HIV disease have deliberately recidivated in order to receive medical care. When New York correctional authorities have been unable to arrange adequate care in the community for an inmate with AIDS scheduled for parole, they have, with the inmate's consent, delayed his or her release. However, release cannot be delayed beyond the expiration of an inmate's maximum sentence.[15] Similarly, Colorado correctional officials report that they will not permit an inmate with AIDS to have early release unless they have someone to care for them in the community.[16]

Correctional officials must resist the temptation to "dump" prisoners with AIDS into the community without arrangements for their care and support. Discharge planning is crucial. Before being released, inmates with HIV disease must be linked up with all appropriate programs and resources in the community. NIJ survey results indicate that two-thirds to three-quarters of systems in all categories attempt to link up HIV-infected inmates with social services in the community prior to their release. This planning should include ensuring inmates' eligibility for relevant benefit programs and assistance with application procedures, as well as arranging the individual's acceptance for care at a specific hospital, hospice, or other appropriate facility.

## Endnotes

1. German Maisonet, Testimony before the National Commission on AIDS, New York, August 17, 1990.
2. *Harris v. Thigpen* 1727 F.Supp. 1564 (M.D. Alabama, 1990).
3. Alexa Freeman (Director, AIDS Project, National Prison Project, ACLU), "Alabama Prison Policies and Practices on AIDS," Testimony before the National Commission on AIDS, New York, August 17, 1990.
4. The following account is based on interviews with Executive Director Frank Gunter, Director of Clinical Services Dennis Kleinsasser, and Associate Director of Clinical Services R.T. Moore, Colorado Department of Corrections, Colorado Springs, December 13, 1990; and with Thomas Cooper and other staff of Territorial Prison, Canon City, Colorado, December 13, 1990.
5. *Ramos v. Lamm* (U.S.D.C., D. Colorado) No. 77-C-1093, March 7, 1990.
6. Interview with inmates in Cell House 3, Territorial Prison, Canon City, Colorado, December 13, 1990.
7. Interview with Executive Director Frank Gunter and Director of Clinical Services Dennis Kleinsasser, Colorado Department of Corrections, Colorado Springs, December 13, 1990.
8. Cathy Potler, "Early Release for Inmates with AIDS," Testimony before the National Commission on AIDS, New York, August 17, 1990.
9. *Ibid.*
10. Interview with Director of Clinical Services Dennis Kleinsasser, Colorado Department of Corrections, Colorado Springs, December 13, 1990.
11. "Prisoner with AIDS May Get Freedom." *CorrectCare*, January 1991.
12. Potler, "Early Release for Inmates with AIDS."
13. Interview with Director of Clinical Services Dennis Kleinsasser, Colorado Department of Corrections, Colorado Springs, December 13, 1990.
14. Potler, "Early Release for Inmates with AIDS".
15. Interview with Chief Medical Officer Dr. Robert Greifinger, New York State Department of Correctional Services, Fishkill Correctional Facility, New York, October 24, 1990.
16. Interview with Director of Clinical Services Dennis Kleinsasser, Colorado Department of Corrections, Colorado Springs, December 13, 1990.

# Chapter 8

# Medical Care and Psychosocial Services

As more is learned about HIV disease and as more prisoners are diagnosed with it, the challenge to correctional administrators of providing medical care and psychosocial services for inmates with HIV becomes more daunting. Legally, as discussed in Chapter 9, correctional systems have generally been required to provide medical care up to community standards rather than to the "state-of-the-art." However, many prison and jail systems do aspire to offer exemplary care. The services constituting a comprehensive program include medical monitoring, early intervention, ongoing provision of medications, access to experimental therapies, specialist care, hospitalization, counseling, and other supportive services. In addition, drug treatment programs represent a critical part of HIV prevention. This chapter discusses a range of issues posed by the effort to improve medical and related services for inmates with HIV.

## Medical Care: Problems and Improvements

According to many observers, the state of medical care for prisoners in general, and for those with HIV disease in particular, is extremely poor. A procession of witnesses came before the National Commission on AIDS to detail the problems that exist—inadequate facilities, poorly trained staff, and high costs amid severe budget constraints, among others. Dr. Robert Cohen, formerly medical director at Rikers Island jail in New York City and an expert on prison medical care, declared that "a dangerously inadequate prison health care system is being overwhelmed by two epidemics: one, the mass incarceration of poor black and Hispanic drug users, and the other, the extraordinary medical demands of the AIDS epidemic."[1] The New York State correctional system spent $6 million in 1990 for zidovudine (often called AZT) and aerosolized pentamidine alone.[2]

In some systems, endemic tensions between medical and security officials make it extremely difficult for adequate care to be provided. In others, medical staff are poorly trained and/or insensitive to the needs of prisoners with HIV and other serious illnesses. Medical monitoring, diagnosis, and treatment for women inmates with, or at risk for, HIV disease have also been identified as particular problem areas. In particular, more attention to the links between HIV and sexually transmitted diseases among women is considered necessary.[3]

Prisoners with HIV disease have brought lawsuits challenging the quality of medical care and related services provided in a number of correctional systems, including those in Alabama and New York.[4] Alexa Freeman, the lead attorney for the Alabama plaintiffs, summarized the allegations regarding Alabama's treatment of inmates with HIV disease in testimony before the National Commission on AIDS: "The contract medical providers assumed that HIV disease was completely untreatable. Prisoners were given Tylenol for their pain and ignored until on the verge of death. Zydovudine was not provided to prisoners until they were almost dead, and helper T-cell counts were never taken. The responsible physicians had never heard of aerosolized pentamidine. Our medical experts testified that every single case of AIDS and symptomatic HIV disease was mishandled. Several prisoners died as a result, and many others suffered unnecessarily."[5] The court decided the case in favor of the correctional department on the ground that "deliberate indifference to serious medical need"—the constitutional test—had not been established. Prisoners are not entitled to state-of-the-art care, the court held, particularly when correctional departments are operating under severe budgetary limitations.[6] The decision is currently on appeal.

### *Zidovudine and Aerosolized Pentamidine*

Figures 20 and 21 summarize the 1990 NIJ survey's findings on the availability of zidovudine and aerosolized pentamidine to prisoners with HIV disease. As in last year's survey, virtually all U.S. systems and a majority of

**Figure 20**

**PROVISION OF ZIDOVUDINE FOR INMATES, OCTOBER 1990[a]**

| | U.S. State/Federal Prison Systems (N=51) | | U.S. City/County Jail Systems (N=27) | | Canadian Systems (N=12) | |
|---|---|---|---|---|---|---|
| | Number of Systems | % | Number of Systems | % | Number of Systems | % |
| Zidovudine Provided | 48 | 94% | 27 | 100% | 7 | 58% |
| Eligibility Criteria | | | | | | |
| CD4 (T-4) count < 500 | 40 | 78 | 16 | 59 | 4 | 33 |
| CD4 (T-4) count < 400 | 2 | 4 | 0 | 0 | 0 | 0 |
| CD4 (T-4) count < 350 | 1 | 2 | 0 | 0 | 0 | 0 |
| CD4 (T-4) count < 200 | 1 | 2 | 0 | 0 | 0 | 0 |
| All HIV-positive inmates | 0 | 0 | 3 | 11 | 1 | 8 |
| Doctor's Orders | 1 | 2 | 5 | 18 | 1 | 8 |
| Other/Unspecified | 3 | 6 | 3 | 11 | 1 | 8 |
| Provided to All Who Qualify | 46 | 90 | 26 | 96 | 6 | 50 |

[a]Includes systems with policies under revision.

*Source:* NIJ Questionnaire Responses.

Canadian systems report that zidovudine is available to their prisoners. The major improvement has come in adherence to the FDA's eligibility criterion for zidovudine—individuals with CD4 (T4) counts of 500 or below. In 1989, only 31 percent of State/Federal systems reported meeting this criterion; in 1990, 78 percent of systems have policies meeting this standard, and 90 percent state that all inmates in this category actually receive zidovudine. In the New York State system alone about 1500 prisoners are on zidovudine. New York has instituted some innovative procedures for the administration of zidovudine. Because of the number of inmates on the medication, it is logistically impossible to have staff directly monitor dosage compliance around-the-clock. There are also threats to confidentiality in having officers waking up selected inmates to take medications during the night. Thus, in the New York system, the vast majority of inmates are responsible for taking their own medication. Only those with histories of unreliability in this regard are directly monitored for compliance. To further protect confidentiality, the pharmacy at one institution removes the telltale label from the zidovudine bottle before the medication is dispensed. This step was taken at the suggestion of an inmate.[7]

Among responding city/county systems, the percentage meeting the FDA criterion for zidovudine provision increased from 26 percent to 59 percent. Virtually all jail systems report that all inmates eligible for zidovudine under their criteria were actually on the medication.

Figure 21 summarizes the availability of aerosolized pentamidine (AP) to inmates. Eighty percent of State/Federal systems (up from 75 percent in 1989), 56 percent of responding city/county systems (up from 45 percent a year ago), and one third of Canadian systems (up from only 9 percent in 1989) provide AP. However, the percentages of systems with eligibility criteria conforming to the Public Health Service standard (CD4 count below 200) have not changed much since 1989. Only 37 percent of State/

**Figure 21**

**PROVISION OF AEROSOLIZED PENTAMIDINE (AP) FOR INMATES, OCTOBER 1990**

| | U.S. State/Federal Prison Systems (N=51) | | U.S. City/County Jail Systems (N=27) | | Canadian Systems (N=12) | |
|---|---|---|---|---|---|---|
| | Number of Systems | % | Number of Systems | % | Number of Systems | % |
| Aerosolized Pentamidine (AP) Provided | 41 | 80% | 15 | 56% | 4 | 33% |
| Eligibility Criteria | | | | | | |
| CD4 (T-4) count < 200 | 19 | 37 | 4 | 15 | 0 | 0 |
| CD4 (T-4) count < 250 | 0 | 0 | 1 | 4 | 0 | 0 |
| CD4 (T-4) count < 500 | 2 | 4 | 1 | 4 | 0 | 0 |
| All HIV-positive inmates | 1 | 2 | 2 | 7 | 0 | 0 |
| PCP Episode | 3 | 6 | 2 | 7 | 0 | 0 |
| Other/Unspecified | 4 | 8 | 2 | 7 | 1 | 8 |
| Doctor's Orders | 12 | 24 | 3 | 11 | 3 | 25 |
| Provided to All Who Qualify | 38 | 75 | 12 | 44 | 2 | 17 |

*Source:* NIJ Questionnaire Responses.

Federal systems, 15 percent of responding city/county systems, and no Canadian systems have policies embodying this minimum criterion. Still, some systems have instituted widespread use of AP. In New York State, about 800 inmates currently receive this therapy to prevent the onset or recurrence of *Pneumocystis carinii* pneumonia.[8]

## *Other Developments in New York State*

The New York State correctional system has come under heavy criticism for its medical treatment of HIV-infected inmates,[9] and, as noted, the department is currently being sued by inmates with HIV disease. However, it is important to note the improvements that have been made in the medical services provided in this system which has, by far, the largest number of inmates with HIV disease. Much of the improvement has been due to changes made by Dr. Robert Greifinger, who came from Montefiore Hospital to become Deputy Commissioner and Chief Medical Officer in the system. With the appointment of Greifinger, the system had a physician heading its health services for the first time, and the position was elevated to the deputy commissioner level.[10]

Greifinger has attempted to address some of the major criticisms leveled against the department. He has centralized the administration and fiscal management of the

Division of Health Services, instituted more thorough monitoring of health services at the institutional level (by means of regular visits to all facilities), brought in new and better qualified medical staff in many institutions, renovated and upgraded several of the Special Needs Units where some prisoners with AIDS are housed, provided for the addition of substantial beds for prisoners with HIV at a new hospital facility, and planned a computerized system to make scheduling of and transportation of inmates to off-site medical appointments more efficient. Greifinger admits that there is still room for improvement in New York but feels that substantial progress has been made.[11]

### *Rhode Island: A Cooperative Program with Continuity of Care*

In Rhode Island, an innovative program has been developed to provide inmates with a comprehensive range of HIV-related services, including AIDS education, HIV testing and counseling, complete on-site ambulatory care, pre-release counseling, and post-release clinical followup.[12] These services are provided in the State's Adult Correctional Institution by a multi-disciplinary HIV management team consisting of an attending physician and rotating infectious disease fellows from Brown University, two AIDS education specialists, and a registered nurse. Funding is provided by the State department of health.

The most innovative features of the Rhode Island program are that it is a cooperative effort of the State health department, the correctional department, and a private university and that it offers continuity of care from incarceration to post-release. The HIV management team uses the prison's medical facilities but operates as a "specialized consultative service." All HIV-seropositive inmates are referred to the team and may request a clinical evaluation at any time. Six prisoners whom the team did not know were HIV-infected came forward voluntarily for clinical services. In its first ten months of operation, the HIV management team in Rhode Island served over 200 prisoners and had an active caseload of over 100.

Continuity of management and care are important features of the program. Inmates with HIV who are about to be released are referred to community-based services but are also followed by members of the Brown University AIDS Program. Indeed, in most cases, they are treated after release by the same physician who provided their care while they were incarcerated. With the help of communication between the HIV management team and inmates' families, compliance rates with post-release medical appointments have been very high, especially considering that most of these former prisoners have histories of serious drug use.

The program has resulted in enhanced efficiency in care delivery and substantial cost savings for the correctional department by avoiding many expensive visits to off-site facilities. The venture has also been beneficial to Brown because it provides valuable training opportunities for its infectious disease fellows. Finally, the health department views the program as an important strategy for reducing the spread of HIV in the community at large. In sum, the Rhode Island program is one worthy of replication in other correctional systems.

### *Access to Experimental Therapies and Clinical Trials*

There continue to be important biomedical and clinical research developments in HIV disease. In the wider world, as discussed in Chapter 1, there have been significant improvements in patient access to experimental drugs through clinical trials and otherwise. In prisons and jails, however, such access has thus far been extremely limited. NIJ survey results reveal that only 17-18 percent of State/Federal, responding city/county, and Canadian correctional systems afford their prisoners access to experimental therapies for HIV. An FDA official told the National Commission on AIDS that her agency knew of some efforts to recruit prisoners into clinical trials of HIV therapies but none that had been successful in enrolling inmates either individually or as a group.[13]

Federal regulations, promulgated in 1983 with the worthy purpose of ending a long history of exploitation of prisoners in medical research, have effectively excluded inmates from clinical trials of any drugs. Contending that true informed consent and confidentiality are impossible to achieve in prisons, some have called for the continued exclusion of clinical trials from correctional institutions.[14] However, in the past few years, there have been increasing calls for the liberalization of the regulations so that prisoners might enroll.

Advocates of liberalization do not deny the problems of obtaining true informed consent and preserving confidentiality in correctional facilities. Nevertheless, they argue that prisoners should be able to make their own decisions regarding participation in research rather than having their decisions made on the basis of outsiders' opinions. Notably, these advocates favor prisoner access to nonplacebo

Phase II and III (efficacy) trials but oppose their enrollment in Phase I (safety and toxicity) trials.[15] Dr. Robert Levine, Professor of Medicine at Yale University, has put the point very forthrightly: "Policies that obstruct prisoners' access to investigational new drugs constitute deprivation of opportunities to pursue amelioration of life-threatening disease."[16]

Prisoner access to experimental drugs through clinical trials requires not only revision of federal regulations but also the cooperation and support of correctional officials. Removing regulatory barriers alone will not ensure that prisoners will actually obtain these new therapies.

## Drug Treatment

Expanded and enhanced drug treatment must be a key part of a comprehensive HIV prevention and treatment strategy in prisons. Correctional populations include high concentrations of substance abusers, so prisons and jails offer perfect opportunities for treatment. Treatment options in correctional institutions run the gamut from 12-step and other self-help programs such as Narcotics Anonymous to intensive residential programs based on the therapeutic community model. However, even including general drug education and self-help programs as treatment, a 1987 NIJ survey found that only 11 percent of U.S. inmates were enrolled.[17] The percentage of inmates who could benefit from treatment is certainly much higher.

Drug treatment—particularly intensive residential treatment—is expensive, but offering more and better treatment for inmates would seem to represent an important opportunity for correctional systems. Termination or even reduction in drug use has many potential benefits. It may not only help inmates to avoid becoming infected with HIV infection themselves and infecting others but also may assist them in gaining control of their lives, becoming productive citizens, and ending patterns of repeated crime and incarceration. All of this obviously benefits society as a whole, as well as individual prisoners.

Some correctional systems do offer high-quality drug treatment. For example, New York's Sing-Sing Correctional Facility has several intensive residential programs within the walls. These have achieved good success rates. However, they only have enough beds to serve a small fraction of the inmates in need. Expansion and diversification of drug treatment in corrections remains an urgent priority.

## Psychosocial and Supportive Services

Counseling and supportive services are useful not only in fostering and maintaining HIV risk reduction for uninfected persons but also for assisting persons cope with the grave difficulties of adjusting to HIV disease. AIDS service organizations in the community have evolved a range of sensitive individual and group support programs for persons with HIV disease. Such programs are at least as necessary in correctional settings. It is stressful to be in prison, but the problems engendered by being incarcerated are greatly magnified by a diagnosis of HIV disease.

Many correctional systems offer special counseling and services for HIV-infected prisoners. However, in many facilities counselors must carry such heavy caseloads that it is difficult for them to become intensively involved with any individual inmate. At Fishkill Correctional Facility in New York, for example, two counselors conduct support group sessions for HIV-infected inmates, but they do so on their own time after they serve their normal caseload of other inmates.[18] Very few correctional facilities have professional counselling staff assigned full-time to serving HIV-infected prisoners.

Since their staff counseling resources are so often limited, some correctional systems have shifted some of the burden of supportive services for inmates with HIV disease to other inmates or outside groups, both of whom may be eager to help. Slightly over half (55 percent) of State/Federal prison systems and less than half of responding city/county (44 percent) and Canadian (42 percent) systems report having peer counseling or supportive programs for HIV-infected inmates.

The ACE program at Bedford Hills, New York is perhaps the best example of an inmate-initiated supportive program. The women of ACE not only conduct AIDS education programs but also maintain a "buddy" system and hold regular support groups for women with HIV/AIDS. In addition, ACE provides medical advocacy—that is, ACE members will accompany inmates to medical appointments to help ensure that they are treated fairly and receive appropriate treatment.[19]

A second alternative for correctional systems is to make use of outside organizations to provide counseling and supportive services. The 1990 NIJ survey results suggest that many correctional agencies are now working with such external groups. About 60 percent of all responding

U.S. systems and two-thirds of Canadian systems report using AIDS service organizations in their facilities. There is an active network of AIDS service organizations working in British prisons as well.[20]

In the United States, Philadelphia's ActionAIDS offers a good example of what these groups can do. Volunteers from ActionAIDS have worked with prisoners and their families for several years, offering individualized counseling and support. Anna Forbes of ActionAIDS believes that the organization has helped many prisoners in area facilities to overcome the isolation that may come from being incarcerated and having HIV disease. The group also assists parolees and others coming out of prison to obtain needed services.[21]

ActionAIDS gained access to the prisons through the advocacy of prison social services staff. However, as Anna Forbes notes, many AIDS organizations have met resistance from correctional administrators when they have offered their services to inmates. Some administrators are naturally suspicious of outside agencies involving themselves in correctional facilities. In this case, however, it would seem that such involvement offers needed services which correctional systems often cannot afford to provide themselves.

## Endnotes

1. Quoted in "Prisons' Care Systems Swamped by AIDS Epidemic, Panel Told," *AIDS Policy and Law* September 5, 1990, p. 3.

2. Interview with Deputy Commissioner/Chief Medical Officer Dr. Robert Greifinger, New York State Department of Correctional Services, Fishkill Correctional Facility, New York, October 24, 1990.

3. Brenda V. Smith, Director of Women in Prison Project, National Women's Law Center, "Women in Prison and HIV Infection: Perspectives and Recommendations," Testimony before the National Commission on AIDS, New York, August 17, 1990.

4. *Inmates of New York State with HIV v. Cuomo* (U.S.D.C., N.D. New York) No. 90-CV-252; Michael Wiseman, Prisoners' Rights Project, Legal Aid Society of the City of New York, Testimony before the National Commission on AIDS, New York, August 17, 1990.

5. Alexa Freeman, "Alabama Prison Policies and Practices on AIDS," Testimony before the National Commission on AIDS, New York, August 17, 1990.

6. *Harris v. Thigpen* 727 F.Supp.1564 (M.D. Alabama, 1990).

7. Interviews with Dr. Robert Greifinger (Deputy Commissioner/Chief Medical Officer) and Dr. Ivan Mikler (Medical Director) Fishkill Correctional Facility, October 24, 1990; Interviews with medical staff at Sing-Sing Correctional Facility, Ossining, New York, October 25, 1990.

8. Interview with Dr. Robert Greifinger, Fishkill Correctional Facility, New York, October 24, 1990.

9. See, for example, Cathy Potler, "AIDS in Prison: A Crisis in New York State Corrections," Correctional Association of New York, 1988; New York State Department of Health – AIDS Institute, AIDS Advisory Council, Ad hoc Committee on AIDS and Correctional Facilities, "Management of HIV Infection in New York State Prisons," November 1989.

10. Interview with Dr. Robert Greifinger, Fishkill Correctional Facility, October 24, 1990.

11. *Ibid.*

12. The following discussion of the Rhode Island program is based on P.S. Dixon et al., "Rhode Island's Cooperative HIV Management Program for Prison Inmates," draft submitted for publication, 1990; also P.S. Dixon et al., "A Comprehensive Program of Health Care for HIV-Infected Prisoners," Abstract No. Th.D.892, Sixth International Conference on AIDS, San Francisco, June 21, 1990.

13. Ann A. Graham, Office of Health Affairs, FDA, Testimony before the National Commission on AIDS, New York, August 17, 1990.

14. For example, Billy Jones, Testimony before the National Commission on AIDS, New York, August 17, 1990.

15. See, for example, N. N. Dubler and V.W. Sidel, "On Research on HIV Infection and AIDS in Correctional Institutions," *Milbank Quarterly* 1989; 67: 171-205; T.M. Hammett and N.N. Dubler, "Clinical and Epidemiologic Research on HIV Infection and AIDS Among Correctional Inmates," *Evaluation Review* October 1990; 14: 482-501.

16. Dr. Robert Levine, Testimony before the National Commission on AIDS, New York, August 17, 1990.

17. M.R. Chaiken, *In-Prison Programs for Drug-Involved Offenders* (Washington D.C.: National Institute of Justice, July 1989), p. 5.

18. Interview with counselors Jason Di Palma and Suzanne Norsby, and interviews with inmates in the Special Needs Unit, all at Fishkill Correctional Facility, New York, October 24, 1990.

19. K. Boudin and J. Clark, "Community of Women Organize Themselves to Cope with the AIDS Crisis: A Case Study from Bedford Hills Correctional Facility," *Social Justice* 1990; 17: 90-107; "Bedford Hills' ACE Program Helping Eliminate Fear, Stigma," *AIDS Policy and Law* August 8, 1990, pp. 5-6.

20. A. Kelmanson et al., "A Consortium of UK Voluntary Organizations Making Links Between Prisons and Community Support/Education Groups," Abstract No. Th.D.881, Sixth International Conference on AIDS, San Francisco, June 21, 1990.

21. Anna Forbes, Director of Community Relations, ActionAIDS, Testimony before the National Commission on AIDS, New York, August 17, 1990.

# Chapter 9

# Legal Issues

There continues to be a great deal of HIV-related litigation filed by prisoners, correctional staff and others concerned with prison and jail issues. While many of these cases are still being decided in favor of correctional systems, courts seem to be displaying less reluctance to challenge existing HIV-related policies. Notably, this year for the first time a court overturned one correctional system's mandatory testing policy.

In general, there appears to have been some decline in the number of suits filed by prisoners seeking mandatory testing and segregation of HIV-seropositive inmates. However, suits complaining of inadequate medical care and insufficient confidentiality protections have increased. Cases challenging mandatory testing and segregation policies also continue to be quite common. Finally, there have now been a substantial number of cases involving alleged HIV transmission incidents and sentencing of persons with HIV infection.

## Issues Raised by Inmates

### *Challenges to Mandatory Testing, Segregation, and Restricted Access*

The major types of cases brought by prisoners have challenged policies and practices regarding mandatory and other HIV antibody testing, segregation, restricted access to programming, confidentiality, and medical care. Perhaps the most important development in this area in the past year was the Ninth Circuit Court of Appeals ruling in *Walker v. Sumner*[1] that the Nevada state prison system's mandatory HIV testing policy violated prisoners' rights under the Fourth, Eighth, and Fourteenth Amendments. This was the first decision overruling a correctional system's mandatory HIV testing policy. The court, in reversing the U.S. District Court's decision validating the testing policy,[2] held that the state had offered no evidence that its policy "was reasonably related to legitimate penological interests." (This is the legal test under which many systems' testing and segregation policies have been upheld.)[3] Indeed, the Ninth Circuit stated that the record gave no indication as to how prison officials intended to use information on the HIV status of prisoners. The court concluded that "[d]espite their conviction and confinement, prisoners do not forfeit all constitutional rights."[4]

The reversal in *Walker v. Sumner* stands in marked contrast to the January 1990 U.S. District Court decision in *Harris v. Thigpen* in which mandatory testing and segregation in the Alabama system were upheld as policies adopted in furtherance of legitimate correctional objectives.[5] This case is still on appeal. Mandatory testing and segregation were also upheld in Colorado. The judge ruled that elimination of the policy would be unfair to HIV-negative inmates.[6] Cases challenging mass or individual mandatory testing remain pending in Missouri and Hawaii.[7]

Other cases on testing issues include a Philadelphia suit seeking on-request inmate testing, counseling, and medical intervention (dismissed by the court after hearing evidence that many of the requested changes were being made),[8] a Nevada case in which an inmate claimed to have been tested but not notified of the results until a year later (pending),[9] and an important California case in which that state's law requiring HIV antibody testing of persons alleged to have been involved in possible transmission incidents with peace officers or employees of custodial facilities was upheld. In this case, brought by a defendant who bit a court officer, the court held that such a mandatory test did not constitute an unreasonable search and seizure. There is a possibility—albeit remote—that HIV can be transmitted through a bite, the court argued, and therefore the assailant's test results "would be useful in treating the bitten officer and in easing the officer's anxiety."[10]

When cases challenging segregation policies have reached adjudication, they have generally been decided in favor of the policies. The leading recent decisions in this regard are *Harris v. Thigpen*, *Ramos v. Lamm*, and *Lewis v. Prison Health Services*.[11] However, in several recent settlements and in an administrative decision, segregation policies have been overturned or at least modified. In settling the Connecticut case of *Smith v. Meachum*, the correctional department agreed to cease its practice of segregating all prisoners with AIDS diagnoses in a hospital unit of the maximum security prison.[12] In a settlement of *Gates v. Deukmejian*, California agreed to establish a pilot program for some HIV-infected inmates at Vacaville in which they would continue to live in a separate unit but would go out into population for work and other programming. The pilot program has been established and is reportedly working well.[13] Following an administrative complaint by several Pennsylvania inmates, the Office for Civil Rights of the Department of Health and Human Services held that isolation of HIV-infected prisoners violated the Federal Rehabilitation Act.[14] Several cases challenging segregation policies are pending. These include cases in New Jersey, Missouri, and Broward County, Florida.[15]

This year, the Federal Bureau of Prisons' policy excluding HIV-infected prisoners from work assignments in food service and hospitals was upheld, despite the judge's admission that HIV is not transmitted through food or casual contact with hospital workers. The decision was based on a finding that the policy represented a reasonable "effort to maintain the order and security of the institution."[16] A Nevada case in which an HIV-infected inmate is seeking access to a minimum security camp is pending.[17]

A case with important implications for correctional authorities regarding the confidentiality of information on HIV status reached decision this year. In *Doe v. Borough of Barrington*, the court held that a municipality's failure to train its police officers about HIV disease and officers' unauthorized disclosure of a citizen's HIV-positive status to a neighbor violated the individual's right to privacy under the Fourteenth Amendment.[18] An analogous situation in corrections would probably be an officer's disclosure of an inmate's HIV status to another inmate. Claiming a violation of privacy rights and defamation of character, a Missisippi inmate alleges that county police and public health official falsely told members of the local media that he was infected with HIV. This case is pending.[19]

### *Adequacy of Medical Care*

A great deal of litigation focuses on the adequacy of medical care and associated services for prisoners with HIV disease. It has been argued that medical care for prisoners with HIV suffers from application of a blatant double standard. In testimony before the National Commission on AIDS, Scott Burris of the Pennsylvania ACLU contrasted court findings in *Harris v. Thigpen* and *Hawley v. Evans* to that in *Weaver v. Reagan*, the leading case regarding zidovudine (often called AZT) availability for Medicaid patients. In *Harris*, as in most prison cases, the U.S. District Court for the Middle District of Alabama held that prisoners are not entitled to "state-of-the-art" medicine and that reasonable care according to community standards meets the constitutional requirement.[20] In *Hawley*, the Federal District Court for the Northern District of Georgia declined to order provision of zidovudine for asymptomatically HIV-infected inmates because its efficacy for such patients was in dispute among scientists.[21] In *Weaver*, by contrast, Burris notes that "neither the trial court [U.S. District Court for the Western District of Missouri] nor the court of appeals [Eighth U.S. Circuit Court] were deterred by medical disagreement about the utility of zidovudine and held that zidovudine must be provided under Medicaid coverage."[22]

Recently, a consent judgement in *Doe v. Meachum* mandated a wide range of improvements in care for prisoners with HIV disease in the Connecticut State prison system. These improvements, if implemented, would constitute an exemplary program for medical care and related services. The consent judgement's requirements include the following: provision of infectious disease specialist services at all institutions; designation of a coordinator of AIDS-related medical services at all institutions; systematic intake screening and followup monitoring for persons with, or at risk for, HIV infection; individual treatment plans and followup schedules; referrals to infectious disease specialists; access to experimental drugs on a "compassionate use" and/or treatment IND basis; access to counseling and psychosocial services; careful maintenance of medical records; extensive discharge planning; and thorough quality assurance for all services.[23]

Another prison case regarding adequacy of medical care was decided on a legal technicality. A Federal prisoner with HIV disease had been granted bail by a district court judge pending a ruling on the prisoner's petition for a writ of habeas corpus. The prisoner had sought the writ on the ground that he could not receive adequate medical treatment in the federal prison. However, the Eleventh Circuit

overruled the grant of bail on the ground that a writ of habeas corpus was not the prisoner's proper remedy. Rather, he should seek a ruling as to the constitutionality of his care. In the meantime, he should not be released because even if he were to prevail in a subsequent constitutional claim, he would not be entitled to abatement of his sentence. The court stated that "[l]itigants are not entitled to greater temporary remedies pending litigation than they would be entitled to as the ultimate prevailing party."[24]

There are still major cases on adequacy of medical care waiting to be decided. A very large class action suit, *Inmates of New York State with HIV v. Cuomo*[25], filed in March 1990, is still in the discovery stage and is probably several years from disposition. In a New Jersey case, *Roe v. Fauver*, the judge ruled that a full trial was necessary on several issues, including the adequacy of the medical care provided to prisoners with HIV.[26] A judge refused to dismiss another New Jersey case in which an inmate's parents claim that inadequate medical services resulted in their son's premature death from HIV disease. The court found that the physician had failed to make a proper diagnosis and had treated the patient only with over-the-counter medications.[27] Finally, a prisoner in Pennsylvania has filed a suit alleging that the correctional system's lack of adequate inmate educational programs on HIV prevention violates the Eighth Amendment's guarantee against cruel and unusual punishment since such education is a critical part of minimal health care.[28]

## Issues Raised by Inmates and Staff

### *Suits Seeking Mandatory Testing and/or Segregation*

Issues raised by inmates and staff largely involve calls for mandatory testing and segregation of HIV-infected prisoners, as well as claims and criminal charges based on incidents in which HIV allegedly could have been transmitted. Courts have invariably ruled against calls for mandatory testing and segregation. This is somewhat ironic in view of their seeming reluctance to overrule such policies where they already exist. This pattern of decisions on testing seems motivated by the view that mandatory testing is neither required by the Eighth Amendment's prohibition against cruel and unusual punishment nor prohibited under the Fourth Amendment's prohibition of unreasonable searches and seizures.[29]

In *Hays v. Idaho Department of Corrections*, a state district court found that the department's current policies were adequate to protect inmates from HIV without instituting the mass screening program which the legislature had mandated but for which it had failed to appropriate sufficient funds for implementation.[30] The Pennsylvania Department of Corrections' policy of not segregating inmates with HIV was also upheld,[31] as was a similar policy in the Lubbock County (Texas) jail system. In the latter case, inmates sought segregation, claiming, among other things, that HIV-infected prisoners masturbated in the showers where noninfected prisoners with athlete's foot might be exposed to their semen. The judge dismissed the case on the ground that there was no possibility of HIV transmission by such means.[32]

Finally in a suit for damages, a federal prisoner alleged that the Bureau of Prisons had violated his right to freedom from cruel and unusual punishment by requiring him to share a cell with an HIV-infected inmate. The court dismissed all the claims, stating that the plaintiff had failed to show that the prison system's policies represented "deliberate indifference to serious medical need." Moreover, the court held, the plaintiff had not claimed to have seroconverted to HIV nor had he even presented any evidence that his cellmate would have, or ever had, behaved in any way so as to place him at risk for HIV infection.[33]

### *Criminal Charges for Possible HIV Transmission*

Serious criminal charges including attempted murder have been filed, and convictions obtained, against HIV-infected prisoners who have assaulted and bitten correctional officers. These cases have been founded on the possibility that HIV could be transmitted through such incidents, ignoring the overwhelming scientific evidence that the chances of such a transmission occurring are vanishingly remote. In New Jersey, Gregory Smith was convicted of attempted murder and sentenced to 25 years in prison for allegedly biting a correctional officer. The prosecutor admitted that the likelihood of HIV transmission through a bite was remote and, indeed, conceded that the guard had not seroconverted. However, the prosecutor argued that the attempted murder charge was warranted on the ground that the prisoner believed that he could infect the guard by biting him. AIDS and prisoner advocacy groups have denounced the verdict and sentence as political. Smith claims that the guard cut his hands on Smith's handcuffs while administering the prisoner a racially-motivated beating.[34]

34. *New Jersey v. Smith* (New Jersey Superior Court, Camden County) No. 2114-8-89, May 18, 1990; "New Jersey Inmate Convicted of Attempted Murder for Biting," *AIDS Policy and Law* May 30, 1990, p. 4; "NJ Jury: Inmate is Guilty of Attempted Murder for Biting Guard," *AIDS Litigation Reporter* April 27, 1990, p. 4372.

35. *Texas v. Weeks* (Texas District Court, Walker County) No. 15-183, November 4, 1989; Belbot and del Carmen, "AIDS in Prisons," p. 150.

36. *Texas v. Prysock* (Texas District Court, Coryell County) No. 12077, February 22, 1990; Judy Greenspan, Testimony on Behalf of Prisoners with HIV Disease/AIDS, National Commission on AIDS, New York, August 17, 1990.

37. *Scroggins v. Georgia* (Georgia Court of Appeals) No. A90A1140-44, November 5, 1990; "Georgia Appeals Court Upholds Conviction for Biting Officer," *AIDS Policy and Law* November 14, 1990, pp. 3-4.

38. *Indiana v. Haines* 46 Crim.L.Rep. 1138 (1989); Belbot and del Carmen, "AIDS in Prisons," p. 150.

39. *Pennsylvania v. Brown* (Pennsylvania Court of Common Pleas, Centre County) No. 1263 of 1988, December 13, 1989; "Inmate who Threw Excrement Cleared of Attempted Murder," *AIDS Policy and Law* March 7, 1990, p. 4.

40. *Elliott v. Prison Health Services* (Florida Circuit Court, 8th Circuit) No. 87-149CA, April 30, 1990.

41. *New Jersey v. Billela* (New Jersey Superior Court, Appellate Division) No. A-5635-87T4, March 13, 1990; "HIV Infection Not Grounds for Light Sentence, Court Says," *AIDS Policy and Law* May 2, 1990, p. 2.

42. *New York v. Escobales* (New York Supreme Court, Bronx County, Criminal Term, Part N, Justice Quattrochi); "AIDS Victim Given 'Compassionate Release': Denied Dismissal," *AIDS Litigation Reporter* March 23, 1990, p. 4214. *People v. Howard* 559 N.Y.S. 2d 572, _____ A.D. _____ (2d Dept 1990).

43. *People v. Sierra* (N.Y. Sup Ct., Kings Cty.), *AIDS Policy and Law* February 20, 1991, p.6.

44. *New York v. Roman* (New York Supreme Court, Bronx County), September 12, 1990; "Judge Drops Drug Indictment of Defendant Dying of AIDS," *AIDS Policy and Law* October 31, 1990, pp. 2-3.

45. *New York v. Ortiz* (New York Supreme Court, Bronx County, Criminal Term, Part 45) Indictment Nos. 4602/88 and 5984/88, January 29, 1990; "NY Court Voids Criminal Indictments Against Terminally Ill Man," *AIDS Litigation Reporter* March 9, 1990, p. 4150.

46. *People v. Suarez*, (N.Y. Sup. Ct., N.Y. County), Indictment No. 5874/90; "New York Judge Dismisses Charge Against Asymptomatic Defendant," *AIDS Policy and Law* February 20, 1991, pp. 5-6.

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